



U.S. Department  
of Health and  
Human Services

Office of  
Inspector General

Semiannual  
Report to the  
Congress

**APRIL-SEPTEMBER 2002**

Working with Others to Promote, Preserve & Protect the Nation's Well-Being

**part·ner** (pärt'nər) *n.* [ME *partener*, alteration of *parcener*, *parcener*. —see *PARCENER*.] A person associated with another or others in a common activity or interest, esp.: **a.** A member of a business partnership. **b.** A spouse. **c.** Either of two persons dancing together. **d.** One of a pair or a team in a game or sport, as bridge or tennis. —*vt.* **-nered, -nering, -ners.** **1.** To make a partner of. **2.** To bring together as partners. **3.** To be the partner of.

☆ **syns:** PARTNER, ALLY,

*n.* **core meaning:** one who cooperates with another in a venture, occupation, or challenge <*partners in business*> PARTNER implies a relationship, frequently between two people, in which each person has equal status and a certain independence but also has unspoken or formal obligation to the other or others <*law partners*> A COLLEAGUE is a fellow member of a staff or organization <*my editorial colleagues*> An ALLY is one who, out of a common cause, has taken one's side and can be relied on <*were allies in the argument*><*the western Allies*>

**col·lab·o·rate** (kə-lăb'ə-rāt') *vi.* **-rat·ed, -rat·ing, -rates.** [LLat. *collaborare, collaborat-*: Lat. *com-*, together + Lat. *laborare*, to work <*labor, work*.] **1.** To work together, esp. in a joint intellectual effort <*collaborated on a biography*> **2.** to cooperate with an agency or instrumentality with which one is not immediately connected — **col·lab·o·ra·tion** \-,la-bə-'rā-shən\ *n* — **col·lab·o·ra·tive** \-'la-bə-,rā-tiv, -b(ə-)rə-\ *adj or n* — **col·lab·o·ra·tive·ly** \-lē\ *adv*

**co·op·er·ate** (kō-öp'ə-rāt') *vi.* **-at·ed, -at·ing, -ates.** [LLat. *cooperari, cooperat-*: *co(m)-*, together + *operari*, to work <*opus, work*.] **1.** To work or act together toward a common end or purpose. **2.** To practice economic cooperation. —**co·op·era'tor** *n.*

**co·op·er·a·tion** (kō-öp'ə-rā'shən) *n.* **1.** An act of cooperating. **2.** An association for mutual benefit.

**part·ner** (pärt'nər) *n.* [ME *partener*, alteration of *parcener*, *parcener*. —see *PARCENER*.] A person associated with another or others in a common activity or interest, esp.: **a.** A member of a business partnership. **b.** A spouse. **c.** Either of two persons dancing together. **d.** One of a pair or a team in a game or sport, as bridge or tennis. —*vt.* **-nered, -nering, -ners.** **1.** To make a partner of. **2.** To bring together as partners. **3.** To be the partner of.

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## *Message from the Inspector General*

The recent corporate accounting scandals have demonstrated the need for increased corporate responsibility and accountability when dealing with stockholder funds. The Federal Government must hold itself to an even higher standard when overseeing federal funds. Here in the Office of Inspector General, we are committed to ensuring the strict accounting of taxpayer dollars.

The work of OIG over the past few months has illustrated numerous areas where potential financial vulnerabilities exist. One area of concern is the accuracy of data reported by pharmaceutical companies and the impact those data have on the amount the government pays in reimbursement for those drugs resulting in the loss of millions of dollars from Medicare and Medicaid each year. In the coming months we will issue final guidance for pharmaceutical manufacturers on compliance with federal fraud and abuse laws. Additionally, we will issue reports on state efforts to control prescription drug costs and the use of drug rebates in the Medicaid program.

We will also continue to be vigilant in examining the payments made to providers to ensure they are accurate and necessary. This will be done by assessing the accuracy and appropriateness of the processes used to make these payments as well as the extent to which other factors, such as medical necessity or coverage issues, impact payments. At the same time we will continue to aggressively pursue providers who file false claims or make false statements resulting in losses to the Medicare and Medicaid programs.

However, the work of this office is not limited to just the financial viability of the Federal health care programs. Our work on child support enforcement resulted in recoveries to children of over \$6.4 million in FY 2002. In addition, an enforcement initiative led by the OIG resulted in 70 arrests of parents who had repeatedly failed to honor their child support obligations and the return of long overdue monies to those children.

Over the coming months, our office will continue to work to ensure the financial integrity of all the programs within the Department of Health and Human Services. We look forward to working with the provider community to ensure the viability and integrity of the federal health care programs for years to come.

Janet Rehnquist  
Inspector General



# *Highlights*

## *Summary Statistical Accomplishments*

For Fiscal Year 2002, OIG reported savings of over \$21 billion comprised of over \$19.9 billion in implemented recommendations and other actions to put funds to better use, \$426 million in audit disallowances, and \$1.49 billion in investigative receivables. (Details pp. 45, 48, and 53.)

In addition, for this Fiscal Year OIG reported exclusions of 3,448 individuals and entities for fraud or abuse of the federal health care programs and/or their beneficiaries, 517 convictions of individuals or entities that engaged in crimes against departmental programs, and 236 civil actions. (Details pp. 15 and 48.)

## *Bioterrorism Preparedness*

The OIG has continued its initiative to assess the security of a number of departmental assets against terrorist threats along with the readiness and capacity of responders at all government levels to protect the public health in case of a bioterrorist attack. Included in this initiative are reviews of the activities and programs of several departmental operating divisions, including CDC, NIH, and FDA. (Details p. 28.)

## *Child Support Enforcement*

During this period, one of the innovative ways OIG approached child support enforcement included a 2-day sweep in which 70 of the nation's most wanted deadbeat parents in 29 states were arrested. This effort represented the single largest joint OIG and Office of Child Support Enforcement crackdown on child support defaulters. (Details p. 37.)

## *Prescription Drugs*

The government settled its third case with a major retail pharmacy chain related to claims for partially filled prescriptions. In a model of multi-government cooperation, the Federal Government and 18 states entered into settlement agreements with Eckerd Corporation to resolve the company's liability for billing federal health care programs for full prescriptions when it dispensed only a portion of the medications prescribed. The OIG investigated a variety of other schemes and identified cases of fraud in the use, distribution, or billing for prescription drugs. (Details p. 20.)

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### ***Medicare Contractor Settlement***

In the second largest health care fraud settlement to date involving a Medicare carrier, General American Life Insurance Company, Inc., agreed to pay the government \$76 million. The settlement resolved allegations that the former Medicare carrier engaged in improper claims handling and quality assurance reporting practices in order to maintain a high performance ranking. (Details p. 24.)

### ***Capped Rental Payments***

The OIG recommended that CMS eliminate the maintenance agreement payment for rental equipment and, instead, pay only for repairs when needed—a change resulting in approximately \$100 million being saved each year by Medicare and its beneficiaries. (Details p. 12.)

### ***Aid to Families With Dependent Children Overpayments***

As part of a nationwide initiative, OIG found that several states and localities had not remitted to the Federal Government its proportionate share of Aid to Families with Dependent Children overpayments. Refunds totaling \$88.8 million were recommended during this reporting period. (Details p. 35.)

### ***Ambulance Services***

American Medical Response, Inc., the nation’s largest ambulance provider, agreed to pay the government \$20 million to resolve civil claims alleging improper Medicare billings. The federal civil charges involved claims submitted to Medicare for nonemergency ambulance transports provided in Massachusetts. (Details p. 23.)

### ***Recruiting and Retaining Foster Parents***

An OIG study on efforts to recruit and retain foster parents found that, while the number of children entering foster care is increasing, the number of available foster parents is decreasing. More could be done to effectively use current foster parents for recruiting, as they themselves may be the most effective recruitment tool. (Details p. 34.)

### ***Clinical Trial Web Sites***

At OIG’s recommendation, the FDA and the Office for Human Research Projects agreed to provide guidance and facilitate the adoption of standards and encourage review of clinical trial web sites as a result of a study which showed that these sites, although in need of improvements, are emerging as an important recruitment strategy and show promise as a means of fostering informed consent. (Details p. 28.)

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***Please Note: Figures throughout the text have been rounded for reporting purposes.***



# *Centers for Medicare and Medicaid Services*

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The Centers for Medicare and Medicaid Services (CMS) administers the Medicare and Medicaid programs. Financed by the Federal Hospital Insurance Trust Fund, Medicare Part A provides hospital and other institutional insurance for persons aged 65 or older and for certain disabled persons. Medicare Part B (Supplementary Medical Insurance) is an optional program which covers most of the costs of medically necessary physician and other services and is financed by participants and general revenues.

The Medicaid program provides grants to states for medical care for qualifying people with low incomes. State expenditures for medical assistance are matched by the Federal Government using a formula that measures per capita income in each state relative to the national average. The State Children's Health Insurance Program (SCHIP), created under the new title XXI of the Social Security Act, expands health coverage to uninsured children whose families earn too much for Medicaid, but too little to afford private coverage.

The Office of Inspector General (OIG) continues to devote significant resources to investigating and monitoring the Medicare and Medicaid programs. These activities have helped ensure the cost-effective delivery of health care; improved the quality of health care; and reduced the potential for fraud, waste, and abuse. In addition, these efforts have often led to criminal, civil, and/or administrative actions against perpetrators of fraud and abuse.

The OIG also reports on the audits of CMS financial statements—which presently account for more than 82 percent of Department of Health and Human Services (HHS) outlays. In addition to issuing an opinion on the statements, auditors assess compliance with Medicare laws and regulations and the adequacy of internal controls.

**PHYSICIAN INCENTIVE PLAN**

Medicare+Choice organizations are prohibited from linking physician incentives to reducing or limiting necessary medical services to specific Medicare patients. They are also required to report all of their physician incentive plan arrangements to CMS annually. The OIG found that the data CMS collects on physician incentive plans do not detect whether these plans restrict access to needed services. Furthermore, this information is incomplete, unreliable and inconsistent. Medicare+Choice organizations indicate that the reporting process is burdensome and costly.

The OIG recommends that CMS replace the current reporting system with a less burdensome and more effective approach. The CMS has agreed to modify the reporting requirements. (OEI-05-00-00010)

**NONPHYSICIAN SURGERY STAFF**

Acting on a request from CMS, OIG found that Medicare pays surgeons or hospitals for nonphysician clinical staff involved in cardiothoracic surgery, even though surgeons do not receive additional payments for some of the staff they bring to the hospital. Recognizing this, some hospitals and cardiothoracic surgeons have entered into arrangements whereby hospitals provide some compensation to those surgeons who bring their own staff.

**Sample reasons cardiothoracic surgeons use personal staff**

Reason	Percent*
<input type="checkbox"/> Hospital lacking staff to assist	75.1
<input type="checkbox"/> Personal staff is efficient and appropriately trained in surgical technique	73
<input type="checkbox"/> Hospital staff does not have right skills	57
<input type="checkbox"/> Hospital does not have staff for preoperative and postoperative care	34.6
<input type="checkbox"/> Personal preference	30.4

\*Surgeons may have cited more than one reason. The CMS concurred with the findings, as they affirmed CMS' decision to exclude the costs of physicians' clinical staff used in the facility setting from Medicare's practice cost calculations. (OEI-09-01-00130)

**INCORRECTLY REPORTED HOSPITAL TRANSFERS**

Medicare paid 1,610 hospitals an additional \$6.8 million because the hospitals reported patients as having left against medical advice (called LAMA

discharges), when, in actuality, the patients were admitted to another hospital on the same day. This problem occurred primarily because LAMA discharges are not included in the computerized system edits designed to detect same-day discharge and admission to another hospital.

The OIG, in addition to recommending the recovery of overpayments, recommended that CMS review the instructions for correct hospital coding of patient discharges and develop adequate internal controls and monitoring safeguards to detect and address transfers reported as LAMA discharges. The CMS generally concurred. (A-06-99-00045)

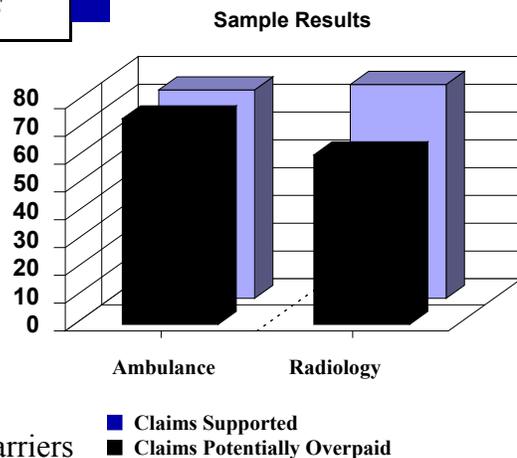
### **IMPROPERLY REPORTED AND PAID DISCHARGES**

The objective of this review was to determine whether hospitals that ceased to exist after consolidation with another hospital improperly submitted claims for prospective payment system discharges. Medicare regulations require that such payments be made to the legal owner on the date of discharge. The review revealed that 15 hospitals that ceased to exist after consolidation were improperly paid \$8 million for 1,118 prospective payment system discharges. These claims were submitted and paid because neither the fiscal intermediaries nor the hospitals had a clear understanding of Medicare payment rules on hospital consolidations. The Department of Justice has reached settlements and fiscal intermediaries have begun collecting the overpayments.

The OIG recommended, among other things, that CMS determine whether instructions should be revised to clarify claim filing and cost reporting after consolidations. The CMS fully concurred. (A-06-00-00044)

### **AMBULANCE AND RADIOLOGY SERVICES**

This review found that Medicare potentially overpaid \$51 million for Medicare Part B ambulance and radiology services provided to inpatients in prospective payment system hospitals. These services should not have been paid separately because they were included in the hospital's diagnosis-related group payment. Instead, the ambulance or radiology provider should have billed the hospital for the services. Neither CMS nor its carriers had adequate controls to detect and prevent these payments.



The CMS generally concurred with OIG's recommendations and stated that mechanisms were already in place to identify and follow up with carriers that process a disproportionate share of questionable claims. (A-01-01-00502)

### **ADJUSTED COMMUNITY RATE PROPOSALS**

This report summarizes the results of OIG's reviews of 186 adjusted community rate proposals submitted by 55 Medicare+Choice (M+C) organizations for contract year 2000. The reviews were requested by CMS and required by statute.

As outlined in CMS regulations, the contract year 2000 proposals were to be prepared using a new methodology intended to more accurately represent the actual costs of Medicare benefit packages. The OIG found, however, that 49 percent of the proposals reviewed had not been prepared in accordance with CMS instructions and that 66 percent contained errors. In addition, 36 percent of the proposals overstated the beneficiary premium/cost-sharing amounts and/or did not provide for additional benefits. The CMS generally concurred with OIG's recommendations to improve the preparation and accuracy of future adjusted community rate proposals. (A-09-01-00051)

### **MANAGED CARE ADDITIONAL BENEFITS**

Through adjusted community rate proposals, M+C organizations present to CMS their estimates of the funds needed to cover the costs of providing the Medicare package of covered services to enrollees. The proposals may also include estimates of additional benefits, such as prescription drugs and eyeglasses, that the organizations plan to offer to Medicare enrollees. The objective of the following audits was to assess whether additional benefits were available to Medicare beneficiaries at reasonable costs and as advertised and whether these benefits were both credible and properly valued for calendar year (CY) 2000.

#### ***Two Southwestern MCOs***

In one report, OIG found that an M+C organization provided additional benefits as proposed in its CY 2000 proposal and as advertised in its marketing brochures. The organization also provided prescription drugs to Medicare enrollees at reduced rates by taking advantage of negotiated discounts. However, the review disclosed problems with the prescription drug benefit component of the proposal that impacted both the Medicare beneficiaries enrolled in the plan and the organization itself. The company no longer participates in the M+C program. (A-06-00-00073)

Reviewing a second M+C organization, OIG found that, with the exception of chiropractic care services, additional benefits estimated in the CY 2000 proposal were available to beneficiaries at the levels and copayments priced in the proposal. Over \$107,000 was estimated for chiropractic services that were not supported or offered to members. In agreement with OIG recommendations, the company revised, among other things, its proposal preparation and pricing methodology to ensure that only additional benefits available to beneficiaries are included. (A-06-01-00064)

### ***DUALLY ELIGIBLE BENEFICIARIES WITH INSTITUTIONAL STATUS***

Medicare provides enhanced payments to managed care organizations for the medical care of dually eligible Medicare and Medicaid beneficiaries and for beneficiaries residing in nursing homes. This report points out a disparity between the payments and the cost of medical care for those dually eligible beneficiaries who resided in nursing homes. Some organizations were significantly overpaid, while others were significantly underpaid. This disparity may have weakened CMS' ability to provide managed care options to beneficiaries. For example, underpayments could reduce the number of managed care organizations willing or able to remain in the Medicare program, and those remaining could be forced to target only healthier beneficiaries for enrollment.

To address this situation, CMS is phasing in a risk adjustment payment methodology, based on the beneficiary's health status, over an 8-year period (2000 through 2007). The OIG recommended that CMS consider the results of OIG's work and seek legislation to accelerate the phase-in of the risk adjustment factors. The CMS generally did not concur. (A-05-00-00015)

### ***PENSION AND POST-RETIREMENT BENEFITS***

In related reports, OIG reviewed records of an insurance company that functioned as a Medicare contractor until its contract was terminated in 2000. The company was allowed to claim Medicare reimbursement for its Medicare employees' pension and post-retirement benefit costs.

Regulations and the Medicare contract provide that pension gains that occur when a Medicare segment of a pension plan closes should be credited to the Medicare program. Accordingly, OIG recommended that the company remit about \$20.2 million in excess pension assets to the Medicare program. Regulations also provide that, to be allowable, post-retirement benefit costs must be funded by the time set for filing the federal income tax return. The costs assigned to the current

year, but not funded by the tax return time, are not allowable in any subsequent year. Since the company's \$3.1 million post-retirement claim was based on unfunded costs, OIG recommended that it withdraw its claim. The company did not agree with the recommendations in either report. (A-07-02-03007, A-07-01-00125)

### ***CARRIER ADMINISTRATIVE COSTS***

The purpose of this review, performed by a CPA firm with OIG oversight, was to determine whether administrative costs claimed by an insurance company to administer Medicare Part B from October 1, 1993, through December 31, 1999, were reasonable, allocable, and allowable. The report recommended for disallowance about \$42.8 million of administrative costs and identified material internal control weaknesses in the areas of indirect costs, fringe benefits, miscellaneous costs, and termination costs. The company did not agree with the findings and recommendations. (A-07-01-02086)

### ***DEPORTED BENEFICIARIES***

Based on a review requested by the Senate Finance Committee, this report points out that the Medicare program is vulnerable to improper payments for services rendered to deported beneficiaries. Of an identified 1,072 deported Medicare beneficiaries, 49 had improper payments totaling \$837,000 made on their behalf during 1998 and 1999. These payments occurred because CMS did not use deportation information in its main database of Medicare enrollment data for processing payments to fee-for-service or managed care providers.

In addition to recommending financial adjustments, OIG recommended that CMS use the deportation information already in its possession to preclude such improper payments. The CMS generally concurred. (A-04-01-05004)

### ***PAYMENTS FOR NAIL DEBRIDEMENT***

Medicare paid approximately \$97 million for inappropriate nail debridement and related podiatry services in Calendar Year (CY) 2000. About 23 percent of nail debridement claims OIG reviewed were not supported by medical documentation, and OIG estimated that Medicare paid \$51 million for such inappropriate claims. Additionally, Medicare erroneously paid for related podiatry services normally associated with nail debridement claims. Since about 23 percent of claims for nail debridement services were not medically supported, any payments

for services related to those claims were inappropriate. The OIG estimated that, for CY 2000, Medicare paid about \$46 million for such related services. Finally, 36 percent of Medicare beneficiaries reported they did not receive nail debridement services paid for by Medicare.

The OIG recommended that Medicare carriers closely scrutinize, through focused medical reviews, all claims for nail debridement services and that CMS regional offices and carriers should also educate podiatrists on Medicare policy for payment of these claims. The CMS agreed. (OEI-04-99-00460)

### **PRESCRIPTION DRUG BENEFITS**

This report addresses information made available to Medicare beneficiaries to enable them to compare prescription drug benefits among Medicare+Choice plans in which they may enroll. The OIG found that the information that the plans provide to beneficiaries about certain elements of the drug benefits is incomplete, inconsistent and confusing.

The CMS concurred with OIG’s recommendations to enhance and validate the drug limit information currently collected in the Plan Benefit Package database and provide beneficiaries with education regarding drug benefits. (OEI-03-00-00430)

### **MEDICARE PAYMENTS FOR PRESCRIPTION DRUGS**

In these companion reports addressing Medicare payments for prescription drugs, OIG compared the amount Medicare reimburses for two inhalation drugs—ipratropium bromide and albuterol—to prices available to the Department of Veterans Affairs (VA) and acquisition costs for suppliers. The OIG found that Medicare and its beneficiaries would save over \$500 million annually (\$279 for

**Comparison of Medicare Reimbursement to VA Prices**

<b>Pricing Source for Ipratropium Bromide</b>	<b>Median Price per mg</b>	<b>Cost of Typical Individual Monthly Usage (50mg)</b>	<b>Monthly Medicare Beneficiary Coinsurance Based on Source Price</b>	<b>Potential Annual Medicare and Beneficiary Savings</b>
<b>Medicare</b>	<b>\$3.34</b>	<b>\$167.00</b>	<b>\$33.40</b>	<b>N/A</b>
<b>VA</b>	<b>\$0.66</b>	<b>\$33.00</b>	<b>\$6.60</b>	<b>\$278,854,770</b>

ipratropium bromide; \$264 for albuterol) if these drugs were reimbursed at the median prices paid by VA. Additional savings between \$223-\$262 million

(ipratropium bromide) and between \$226-\$245 million (albuterol) annually were estimated if the drugs were reimbursed at prices available to suppliers.

The OIG offered several recommendations for reducing the excessive reimbursement, among them authorization of a commission to set payment rates and calculating national estimated acquisition costs based on the reported average manufacturer prices. The CMS agreed and anticipates working with Congress and OIG to revise the payment system. (OEI-03-01-00410, OEI-03-01-00411)

### **MEDICAID PAYMENTS FOR PRESCRIPTION DRUGS**

This report points out that Medicaid could save significant dollars in reimbursement to pharmacies for generic prescription drugs. Most states use average wholesale price (AWP), minus a percentage discount, as a basis for reimbursing pharmacies for drug prescriptions. In 1999, this discount averaged about 10 percent nationally, which OIG believes is not sufficient to ensure that reasonable prices are paid. Based on pricing information from pharmacies in eight states, OIG estimated that the actual acquisition cost, nationwide, for generic drugs averaged about 66 percent below AWP. For the 200 generic drugs with the greatest amount of Medicaid reimbursement in 1999, OIG calculated that as much as \$470 million could have been saved if reimbursement had been based on the 66-percent average discount. This savings calculation was limited to ingredient acquisition costs and did not address other costs, such as dispensing fees.

The OIG recommended that CMS encourage the states to bring pharmacy reimbursement for generic drugs more in line with their actual acquisition costs. The CMS concurred and planned to strongly encourage states to review their estimates of acquisition costs and to follow up on state actions. (A-06-01-00053)

Another report followed up on previous work concerning the discounts below AWP commonly available to pharmacy purchasers of brand name and generic drugs. It provides extended analyses of the discounts available for single-source drugs, all drugs without federal upper limits (FUL), multiple-source drugs without FULs, and multiple-source drugs with FULs. The analyses found a wide range of discounts below AWP for pharmacy purchases depending on the category of drug. The current method for reimbursing for brand name drugs and those non-FUL generic drugs that use a single percentage discount did not adequately consider the large fluctuations in actual discounts between brand name and generic drugs noted during OIG's additional analyses.

If state Medicaid programs continue to use a reimbursement system based on AWP, OIG recommended that CMS encourage states to consider adopting a four-tiered payment system to bring pharmacy reimbursement more in line with actual drug acquisition costs. The four tiers would cover single-source innovator

drugs, multiple-source innovator drugs without FULs, multiple-source noninnovator drugs without FULs, and FUL drugs. The CMS agreed with the recommendations. (A-06-02-00041)

### **SCHOOL-BASED HEALTH SERVICES**

The objective of this review was to determine whether expenditures for school-based health claims for the period July 1, 1999, through June 30, 2000, were reasonable, allowable, and adequately supported.

#### **Washington**

The OIG found that the state did not properly implement and monitor the school-based health service administrative match program. As a result, the state claimed \$527,000 for unallowable overhead costs, used non-Medicaid program data for cost allocation, and allowed invalid time studies to be used for federal funding claims. In addition to recommending financial adjustment, OIG made several recommendations concerning program oversight. The state generally concurred. (A-10-01-00011)

#### **Oregon**

Because Oregon did not properly implement and monitor the school-based health services program, the state claimed unallowable expenditures for three educational providers and established certain reimbursement rates and rate increases that were not in accordance with federal regulations. Based on a statistical sample, OIG estimated that the federal overpayment for the three sampled educational providers was at least \$167,000. The financial effect of the unsupported reimbursement rates cannot be determined until the state performs additional analyses. The state concurred with the findings and recommendations. (A-10-01-00006)

### **MENTAL HEALTH SERVICES**

In this report, OIG found that some Medicare carriers did not have local medical review policies for one or more of the mental health services reviewed. When policies were in place, they did not always provide comprehensive and consistent coverage criteria. In addition, documentation requirements for therapy and pharmacologic management were not comprehensive and consistent.

The OIG recommended that CMS require carriers to strengthen vague or incomplete sections of their local policies for mental health services and ensure that policies adequately address all of the elements specified in the local medical review policy format. The CMS concurred. (OEI-03-99-00132)

**RESIDENTS OF INSTITUTIONS  
FOR MENTAL DISEASES**

The objective of these reviews was to determine if controls were in place to preclude states from claiming federal Medicaid funding for 21 to 64 year old residents of psychiatric hospitals that are institutions for mental diseases. Such funding is not permitted, even if the residents are temporarily released to acute care hospitals for medical treatment. The OIG found that controls were not adequate to preclude most of the states examined from making inappropriate claims and recommended, in general, that the states strengthen such controls. The reports also called for financial adjustments.

**California**

This review found that from July 1, 1997, through February 28, 2001, the state claimed about \$551,000 in unallowable funds for residents who were temporarily released to acute care hospitals. State officials disagreed with the findings and recommendations. (A-09-01-00055)

**Florida**

This review indicated that the state generally had adequate controls to prevent improper claims. The OIG reviewed about 3,800 claims totaling about \$19.8 million in Medicaid payments and found only 47 inappropriate claims for acute inpatient hospital care. These claims represented \$79,000 in federal funds.

A separate review noted about \$71,000 in improper claims for medical and ancillary services. The state did not agree with OIG's recommendations for federal financial adjustments. (A-04-01-02003, A-04-01-02008)

**New York**

The OIG estimated that the state improperly claimed \$113,000 during the July 1, 1997, through September 30, 2000, audit period. Of this amount, \$75,000 was for medical and ancillary claims, \$37,000 was for inpatient claims, and \$1,000 was for an improper inpatient psychiatric hospital claim. The state generally agreed with the recommendations. (A-02-01-01006)

Another review found that, for the same period, New York improperly claimed \$84,000 in federal funds for medical and ancillary services provided to residents of state-operated psychiatric hospitals. The state did not agree with a portion of the recommended financial adjustment. (A-02-01-01014)

**Texas**

This review found that for the period September 1, 1997, through August 31, 2000, federal funds totaling \$463,000 were improperly claimed for medical and ancillary

services. The OIG recommended financial adjustments. The state has taken action to address the recommendations. (A-06-01-00054)

**New Jersey**

Although it was state policy not to claim federal funds for medical and ancillary services provided outside psychiatric hospitals, OIG found that for the period July 1, 1997, through June 30, 2001, the state improperly claimed about \$332,000 for such services.

Another review found that, for the same period, the state improperly claimed \$191,000 of federal funds for patients who were temporarily released to acute care hospitals. State officials agreed with recommendations of both reports. (A-02-01-01008, A-02-00-01027)

**DISPROPORTIONATE SHARE  
HOSPITAL PAYMENTS**

Medicaid provides that states may make additional payments, called disproportionate share hospital (DSH) payments, to hospitals for the uncompensated costs of serving disproportionate numbers of low-income patients with special needs. The Omnibus Budget Reconciliation Act of 1993 mandates that these payments not exceed the individual hospitals' uncompensated costs.

**California**

The OIG found that the state made DSH payments to one hospital that exceeded its hospital-specific limit by \$38.7 million. The limit was overstated because the state: 1) calculated the limit using projected amounts instead of actual incurred expenses and payments, 2) did not limit total operating expenses to amounts that would have been allowable under Medicare cost reimbursement principles, 3) included bad debts as an additional operating expense, and 4) double-counted charges for county mental health/substance abuse services and included charges for services provided to inmates and county employees. (A-09-01-00098)

California made DSH payments to another hospital that exceeded its hospital-specific limit by \$15.9 million. The limit was overstated because the state: 1) calculated the limit using projected amounts instead of actual incurred expenses and payments; 2) did not limit total operating expenses to amounts that would have been allowable under Medicare cost reimbursement principles; 3) included bad debts as an additional operating expense; 4) double-counted charges for Medicaid managed care, county health plans, and county mental health/substance abuse services and included charges for services provided to inmates; and 5) reduced uninsured cash payments by allowances for insured patients. (A-09-01-00085)

Both reports made several recommendations, including those for financial adjustments. The state generally disagreed with the findings and recommendations.

***Missouri***

The OIG found that DSH amounts claimed were overstated by \$36.2 million because the state included nonhospital (community mental health center) costs in its DSH calculations. The OIG recommended that the state return the overpayments to the Federal Government, identify and refund similar excessive claims from subsequent years, and implement procedures and controls to prevent similar claims. The state did not concur. (A-07-01-02093)

In another report, OIG pointed out that DSH costs claimed on behalf of state mental hospitals were overstated by \$1.3 million due to a clerical error. The OIG made several recommendations in addition to one for financial adjustment. The state concurred in part. (A-07-01-02089)

***CAPPED RENTAL EQUIPMENT***

The OIG's detailed 5-year analysis, which involved tracking more than 3,500 pieces of capped rental equipment for beneficiaries who decided to rent or purchase the equipment in 1996, demonstrated that Medicare paid substantially more for maintenance on rented equipment than repairs on purchased equipment. Furthermore, an additional analysis of supplier documentation for more than 250 maintenance services from June 2000 found only 9 percent of the capped rental equipment actually received any maintenance and servicing.

For these reasons, OIG recommended that CMS eliminate the semiannual maintenance payment for rental equipment and, instead, pay only for repairs when needed. This change would result in approximately \$100 million being saved each year by Medicare and its beneficiaries. The CMS agreed with the recommendation and stated that they will consider a legislative initiative to eliminate the 15-month rental option all together. (OEI-03-00-00410)

***OUTREACH***

***Industry Guidance***

The OIG has continued to issue advisory opinions, special fraud alerts, special advisory bulletins and other guidance as part of its ongoing effort to promote the highest level of ethical and lawful conduct by the health care industry.

For the period from April 1, 2002, through September 30, 2002, OIG accepted 29 advisory opinion requests and issued 15 advisory opinions.

### ***Compliance Activities***

Because the great majority of providers are honest and wish to avoid fraud and abuse issues, OIG is actively working with the private sector to develop methods to prevent the submission of improper claims and inappropriate conduct. The OIG has already initiated significant outreach efforts with the private sector to encourage these compliance endeavors. The OIG's compliance program guidelines are available on the Internet at <http://oig.hhs.gov> in the "Compliance Tools" and "Fraud Detection & Prevention" sections.

The OIG has developed and released nine compliance program guidances for: clinical laboratories, hospitals, home health agencies, third-party billing companies, durable medical equipment, prosthetics and orthotics suppliers, hospices, Medicare+Choice organizations that offer coordinated care plans, nursing homes, and individual and small group physician practices. The OIG is currently working on compliance guidance for ambulance service providers and the pharmaceutical industry, as well as a revised guidance for the hospital industry.

### ***Provider Self-Disclosure Protocol***

In keeping with a longstanding commitment to assist providers and suppliers in detecting and preventing fraudulent and abusive practices, OIG issued a set of comprehensive guidelines for voluntary self-disclosures, titled "Provider Self-Disclosure Protocol," available on the Internet at <http://oig.hhs.gov> in the "Compliance Tools" section. In addition, it can be found in 63 *Federal Register* 58,399 (October 30, 1998).

Essentially, the Protocol guides providers and suppliers through the process of structuring a disclosure to OIG of matters uncovered that are believed to constitute potential violations of federal laws (as opposed to innocent mistakes that may have resulted in overpayments). Pursuant to the Protocol, an appropriate submission would include a thorough internal investigation as to the nature and cause of the matters uncovered and a reliable assessment of their economic impact (e.g., an estimate of the losses to the federal health care programs). The OIG evaluates each submission to determine the appropriate course of action. To date, OIG has received 160 submissions. Self-disclosure cases have resulted in 32 recoveries and 18 settlements collectively totaling over \$49.7 million. Two examples follow:

- ***Delaware***—Beebe Medical Center voluntarily paid Medicare \$1.9 million to resolve its administrative liability for excess Medicare funds received

during Fiscal Year 2001. These funds were received as a result of inaccurate wage index information unintentionally submitted in their 1997 Medicare cost report.

- ▶ **Florida**—Florida Medical Quality Assurance, Inc., (FMQAI) and its parent company, Alabama Quality Assurance Foundation (AQAF), agreed to pay \$839,000 to resolve their civil and administrative liability for the submission of false Medicare claims between 1996 and 1998. While performing work in Florida under both Medicare and Medicaid contracts, FMQAI sought reimbursement from CMS under the Medicare contract for time and expenses actually expended for the Medicaid contract. After learning of the misallocations, FMQAI and AQAF self-disclosed the matter to OIG and instituted a compliance program.

**FEDERAL AND STATE PARTNERSHIP:  
JOINT AUDITS OF MEDICAID**

One of OIG's major initiatives has been to work more closely with state auditors in reviewing the Medicaid program. The Partnership Plan was developed to foster these joint reviews and provide broader coverage of the Medicaid program. The partnership approach has been an overwhelming success in ensuring more effective use of scarce audit resources by both the federal and the state audit sectors. To date, partnerships have been developed in 25 states. Reports issued to date have resulted in identifying over \$254 million in federal and state savings and have led to joint recommendations for savings at the federal and state levels, as well as improvements in internal controls and computer system operations.

**New York**

This joint review, covering the 4-year period ended December 31, 2000, identified over 7,800 school and preschool claims totaling \$3.4 million in which school districts and counties billed for services that might have duplicated claims by Article 28 facilities (such as hospitals and public health centers). School officials confirmed that approximately \$1.2 million in claims were duplicated and said that these billings occurred because of school district billing errors. Inadequate payment system controls also contributed to the problem. The state agreed with the recommendations for financial adjustments and procedural corrections. (A-02-02-01006)

A second audit found that the state had not maximized Medicaid drug rebate program revenues owed to Medicaid, had not properly tracked or pursued rebate revenues, and had essentially relied on drug manufacturers to remit the rebates they owed. As a result, approximately \$14 million to

\$20 million that should have been recouped during the audit period was not. The report also concluded that the accounting system used for the drug rebate program had serious limitations. Again, the state agreed with the recommendations for financial adjustments and procedural improvements. (A-02-02-01009)

**Illinois**

The objective of this partnership review was to develop and validate a method for identifying practitioners who submitted claims for more time than is feasible in a single day. The time-dependent billing routine identified physicians who billed for one or more 12-hour days during a 2-year period. Two alternate payees billed for physician psychotherapy services, which were not provided by the physicians and thus not reimbursable by Medicaid. The report recommended the state recover unallowable payments to these payees totaling almost \$7.6 million (federal share: \$3.8 million). The state concurred with the findings and recommendation. (A-05-01-00068)

**OIG ADMINISTRATIVE SANCTIONS**

During this reporting period, OIG administered 2,212 sanctions, in the form of program exclusions or civil actions, on individuals and entities for alleged fraud or abuse or other activities that posed a risk to federal health care programs and/or their beneficiaries. These sanction authorities can be found in Appendix F.

***Program Exclusions***

During this reporting period, OIG excluded 2,082 individuals and entities from participating in the Medicare and Medicaid programs, or other federally sponsored health care programs, most as a result of convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of licensure revocation. These included the following:

- ▶ **Illinois**—A former hospital vice president and a physician were excluded for a minimum period of 25 years for their parts in an elaborate scheme to defraud Medicare, Medicaid and private health care programs. The scheme involved the unnecessary hospitalization of hundreds of patients, the payment of kickbacks, and the filing of false claims and fraudulent cost reports. Both were ordered to pay \$5 million in restitution and sentenced to lengthy periods of incarceration.
- ▶ **Indiana**—A podiatrist was excluded for a minimum period of 25 years, sentenced to 60 months incarceration and ordered to pay \$2.7 million in restitution for defrauding the Medicare, Medicaid and TRICARE

programs through a scheme that lasted from 1993 until 1997. A repeat offender, the podiatrist was also excluded during the period of 1994 through 1996 for defaulting on his health education assistance loan.

- ▶ **Wisconsin**—The former owner of a transportation company that provided specialized services to Medicaid beneficiaries was excluded for 25 years, sentenced to over 3 years incarceration and ordered to pay more than \$1.6 million in restitution. Through his company, the owner improperly billed for multiple round trips on a daily basis and for services provided to hospitalized, dead, or relocated beneficiaries.
- ▶ **California**—A medical supply owner/operator was excluded for 15 years after she was convicted of health care fraud and aiding and abetting. As a result of her scheme, committed over a period of two and a half years, the subject was ordered to pay approximately \$894,000 in restitution.

A family physician was excluded for 10 years after he was convicted of sexual battery and sexual exploitation of his patients. This conviction also resulted in the revocation of his physician and surgeon's license.

- ▶ **Missouri**—The chief financial officer of a managed care organization was excluded for 20 years based on his conviction for carrying out a scheme to obtain money by false pretenses from a health care program. He created a fictitious company, then submitted false invoices to his employer for payment. He was ordered to pay approximately \$729,000 in restitution and sentenced to 6 years in jail.

### ***Civil Monetary Penalties Law***

The Civil Monetary Penalties Law (CMPL) authorizes OIG to impose administrative penalties and assessments against a person who submits claims to a federal health care program that the person knows or should know is false or fraudulent. Civil monetary penalties and assessments may also be levied for other conduct proscribed by statute. During this reporting period, OIG collected \$604,500 in civil monetary penalties and assessments under the CMPL and other authorities, including the CMPL provision for patient dumping, discussed below, and the CMPL provision for kickbacks, discussed further in the Criminal and Civil Enforcement section.

### ***Civil Penalties for Patient Dumping***

Between April 1, 2002, and September 30, 2002, OIG collected civil monetary penalties of approximately \$501,000 from 22 hospitals and physicians under the Emergency Medical Treatment and Labor Act, a statute designed to ensure patient access to appropriate emergency medical services. The following

are examples of the alleged violations involved in the patient anti-dumping statute settlements from this reporting period:

- **Nevada**—Lake Mead Medical Center paid \$64,000 to resolve allegations that four patients did not receive appropriate medical screening examinations. In one incident, a 10-month-old infant was denied examination and treatment because he did not have insurance and his parents could not afford the deposit requested by the hospital.
- **Arizona**—El Dorado Hospital paid \$34,000 to resolve allegations that it failed to provide an appropriate medical screening examination and proper stabilizing treatment to an individual who was brought to the emergency room with severe symptoms. Without obtaining a definitive diagnosis, the hospital discharged the patient, who was rushed the next morning to another hospital where he died.

Kingman Regional Medical Center agreed to pay \$35,000 to resolve allegations that it did not properly screen, treat or transfer six patients.

- **Florida**—University Hospital and Medical Center agreed to pay \$20,000 to resolve allegations that it had failed to appropriately screen or stabilize a woman involved in a motor vehicle accident. The patient had sustained damage to her liver during the accident, but was transferred to another hospital after only seven minutes of assessment.

Florida Medical Center agreed to pay \$35,000 to resolve allegations that, based on its failure to accept the patient's insurance, it refused to provide an appropriate medical screening examination to an individual who presented to its emergency department.

### ***Criminal and Civil Enforcement***

One of the most common types of fraud perpetrated against Medicare, Medicaid and other federal health care programs involves the filing of false claims or statements. Such false claims may be pursued under the civil False Claims Act and, in appropriate cases, may also be prosecuted under federal and state criminal statutes. Enforcement authorities can be found in Appendix F. The successful resolution of these matters often reflects the combined investigative efforts and resources of OIG, the FBI and other law enforcement agencies.

One of OIG's responsibilities is to assist the Department of Justice (DOJ) in bringing (and settling) cases under the civil False Claims Act. Many providers elect to settle their cases prior to litigation. As part of the resolution of these cases,

providers often agree to put in place compliance measures to avoid exclusions and to continue to participate in the Medicare program. The integrity programs established by these agreements are designed to prevent a recurrence of the fraudulent activities that gave rise to the case at issue.

In the six months ending September 30, 2002, the government recouped more than \$369 million through False Claims Act civil settlements related to the Medicare and Medicaid programs. Some of these successful settlements, as well as notable criminal enforcement actions, are described below. Summaries are organized by sector of the health care industry involved or by the nature of the offense.

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### ***Mental Health Services***

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- ***California***—The State of California and the County of Los Angeles (County) agreed to pay \$73.3 million to resolve their civil liability under the False Claims Act and Civil Monetary Penalties Law for submitting claims for services provided to minors who were not Medicaid eligible. In addition, the County allegedly sought and received assistance from the state in avoiding a state audit of the overpayments and in concealing their obligation to return these funds.
  
- ***Pennsylvania***—Northwestern Human Services, Inc., (NHS), a provider of mental health services, agreed to pay \$7.8 million and to enter into a 5-year corporate integrity agreement to resolve its civil liability for submitting false claims. From 1995 through 1999, NHS allegedly engaged in a pattern of fraudulent billing for partial hospitalization program services that were not rendered, not medically necessary, or not covered by the rules governing reimbursement for such services.
  
- ***New York***—A psychologist was sentenced to 6 months incarceration and ordered to pay \$300,000 in restitution and a \$30,000 fine for health care fraud. Advising patients that he needed to speak with families in order to enhance therapy, he then obtained and used family members' names and insurance information to bill Medicare and private insurance companies for services not performed.

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### ***Hospitals***

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- Through separate settlement agreements, Tenet Healthcare Corporation (Tenet) agreed to pay a total of \$55.8 million to resolve its liability under the False Claims Act and the Civil Monetary Penalties Law. The combined

amount includes a \$9.8 million settlement with Brotman Medical Center, a Tenet subsidiary that allegedly submitted false claims for rehabilitation services; a \$29 million settlement with Palmetto General Hospital, a facility that allegedly inflated billings; and a \$17 million settlement reached on behalf of 139 hospitals, currently or formerly operated by Tenet, for alleged improper billing of hospital outpatient laboratory services to federal health care programs.

- ▶ Medical College of Wisconsin (MCW) agreed to pay \$8.9 million for allegedly submitting false claims to Medicare over a 6-year period. Audit results indicated that MCW did not have sufficient evidence to show that teaching physicians were personally and identifiably involved in the performance of services rendered by interns or residents and claims were not in compliance with Medicare rules governing coding and reimbursement of physician services.
- ▶ In California, Catholic Healthcare West (CHW) and several of its subsidiaries entered into a settlement agreement and a 5-year corporate integrity agreement to resolve their civil liability for allegedly submitting false Medicare cost reports. As part of the settlement, CHW agreed to pay \$8.5 million to settle allegations raised in a *qui tam* complaint.
- ▶ Howard University (Howard) agreed to pay \$1.8 million for allegedly submitting inappropriate Medicare Part B billings by teaching physicians over nearly 2 years. Howard submitted claims without adequate documentation demonstrating that the services were personally and identifiably provided by faculty physicians and submitted claims that were not in compliance with the rules governing coding for evaluation and management services. As part of the settlement, Howard agreed to enter into a 5-year institutional compliance agreement, which incorporates many elements of its existing compliance plan.
- ▶ University Medical Center of Southern Nevada (UMC) agreed to pay \$1.2 million to resolve its potential liability for improper upcoding of Medicare claims for inpatient treatment of pneumonia between 1992 and 1997. As part of the settlement, UMC also agreed to enter into a 3-year corporate integrity agreement.

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### ***Nursing Homes***

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- ▶ A North Carolina physician and three physician assistants were ordered to pay \$200,000 in joint restitution, to serve time in prison and to pay individual fines for their roles in a Medicare fraud scheme. As principal

owners of a company that provided medical services to nursing home residents, the four knowingly and systematically submitted claims for services that were either not rendered or were not billable to Medicare. Among the services improperly billed were nursing home visits to deceased Medicare beneficiaries, telephone orders given to staff nurses in nursing homes, the review and signing of rehabilitation certifications and care plans prepared by nursing home staff, and the review and signing of consultant pharmacy reviews prepared by the nursing home consultant pharmacist.

- In Delaware, the director of operations for a rehabilitation company was ordered to pay \$52,000 in restitution for conspiracy to commit wire fraud. He conspired with the company's president to alter therapy treatment logs for Medicare patients in skilled nursing facilities served by his company. The two increased the total number of therapy units provided to patients, then submitted inflated invoices for reimbursement.

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### ***Prescription Drugs***

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- ***Florida***—Eckerd Corporation agreed to pay the government \$5.9 million and to enter into a 5-year corporate integrity agreement to resolve the corporation's liability for submitting claims for partially filled prescriptions. A *qui tam* alleged that between 1986 and 2000, the chain pharmacy submitted false claims each time it dispensed only a portion of a prescription to beneficiaries, but billed Medicaid, TRICARE and the Federal Employee Health Benefits Program for the full amount of the prescription.
- ***Maine***—The twenty-first person was sentenced for his role in leading a large-scale OxyContin distribution ring. The man was sentenced to 21 years and 10 months in prison and ordered to pay \$6,000 in restitution for health care fraud, conspiracy to acquire controlled substances by fraud, and conspiracy to distribute and possess with intent to distribute controlled substances. In a related federal case, he was also sentenced to life in prison after being found guilty in a separate jury trial of distribution of a controlled substance resulting in death.
- ***Ohio***—Four individuals were sentenced for participating in a complex conspiracy to acquire and distribute OxyContin and other prescription drugs. Part of a larger drug trafficking conspiracy, the four misused the Medicaid program to fund the majority of prescription drugs involved in the scheme. Among their respective sentences, one Medicaid beneficiary

was sentenced to 12 years in prison and fined \$15,000 for aggravated trafficking of drugs within the vicinity of a school; another beneficiary was sentenced to over 13 years imprisonment and fined \$17,500 for aggravated trafficking in drugs and marijuana.

- **Pennsylvania**—A couple was sentenced to respective terms of 6 months and 3 months incarceration and ordered to pay joint restitution of \$39,000 for conspiracy to submit false statements in connection with health care matters. From 1998 through 2001, the couple improperly received reimbursement for false claims they submitted for prescription medicines.
- **Michigan**—A podiatrist was sentenced to one year and a day confinement and ordered to pay \$10,000 in fines and \$11,000 in restitution for unlawful distribution of a controlled substance and health care fraud. The podiatrist prescribed Vicodin, a controlled substance, to patients without a preliminary examination and for no apparent medicinal purpose.
- **New Hampshire**—A man was sentenced to 46 months imprisonment and ordered to pay \$3,000 in restitution for conspiracy to take and taking OxyContin through force, violence or intimidation. Over the course of two months, the man and his girlfriend robbed three pharmacies and solicited prescriptions from several doctors to acquire OxyContin.

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### ***Durable Medical Equipment Suppliers***

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- **Minnesota**—Medi Mart, Inc., (Medi Mart) and its affiliated organizations agreed to pay the government \$6.1 million to resolve their civil liability under the *qui tam* provisions of the False Claims Act for allegedly submitting false claims to Medicare. Medi Mart is a durable medical equipment (DME) supplier that furnishes health care supplies directly to nursing facility residents and bills on assignment directly to the Medicare program. The government alleged that from January 1995 through December 1997, Medi Mart routinely and impermissibly waived Medicare copayments. As part of the settlement, Medi Mart, through its parent corporation, McKesson Red Line HealthCare Corporation, agreed to enter into a 5-year corporate integrity agreement with OIG.
- **North Carolina**—A DME company owner was sentenced to 13 months in prison and ordered to pay \$200,000 in restitution for mail fraud. From January 1999 through April 2000, the owner billed Medicare for power motorized wheelchairs when he actually provided beneficiaries with less expensive scooters.

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### ***Home Health***

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- ▶ ***Louisiana***—Two owners of a home health agency were sentenced to 7 years incarceration and ordered to pay \$7.3 million in restitution for conspiracy to embezzle and steal from employee pension plans, health care fraud and bankruptcy fraud. In addition, five related corporations were sentenced and held jointly liable for the restitution ordered. The owners billed Medicare for unallowable and personal expenses.
- ▶ ***Colorado***—A woman was ordered to pay \$7,000 in restitution for her role in a conspiracy to defraud Medicare. As co-owners of a home health agency, the woman and a second individual claimed improper expenses on their Medicare cost report, including those related to private business and personal expenses.

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### ***Laboratories***

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- ▶ ***Florida***—Four individuals were sentenced to an average length of imprisonment of 11 years and ordered jointly to pay a total of \$11.7 million in restitution for conspiracy, fraud and money laundering. The four conspired to defraud Medicare and Medicaid by submitting false claims for laboratory tests. To carry out their scheme, the group used confidential Medicare and Medicaid information to prepare laboratory test requisitions for tests not actually performed. Using the requisitions to support the corresponding Medicare and Medicaid claims, the four fraudulently obtained payments from the programs.

Gambro Healthcare Laboratory Services, Inc., (Gambro) agreed to pay the government \$3 million to resolve its liability for submitting improper Medicare claims for clinical laboratory testing services provided to end stage renal disease patients. Based on a *qui tam* complaint, the government alleged that Gambro billed Medicare for laboratory tests that either were not performed, were not ordered by a physician, exceeded the frequency prescribed by the ordering physician, or were not medically necessary. As part of the settlement, Gambro also agreed to amend a corporate integrity agreement already in effect with OIG.

A lab owner who submitted Medicare claims for unnecessary or unrendered services was sentenced to 57 months incarceration for conspiracy to submit false claims and tax evasion and to 36 months incarceration for introduction of misbranded medical devices. Both terms are to be served concurrently with an ongoing term the owner received for trafficking in controlled substances. He was also ordered to pay \$1.5 million in restitution.

- ▶ **Missouri**—As the result of a multi-state Medicare fraud investigation, two men were sentenced to periods of 23 months and 29 months incarceration, respectively. Both men were ordered to pay fines totaling \$100,000 and restitution of \$2 million jointly. The two set up laboratories in seven states to test blood samples from Medicare beneficiaries in Florida and Puerto Rico. From 1994 to 2000, they caused duplicate claims to be submitted.

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### ***Ambulance Suppliers***

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- ▶ American Medical Response, Inc., (AMR), the nation’s largest ambulance provider, agreed to pay \$20 million to resolve its civil and administrative liability for submitting false claims to Medicare. The *qui tam* action involved allegations that from 1993 through 1998, AMR’s Massachusetts subsidiary billed for medically unnecessary services, falsified certificates of medical necessity and engaged in other improper billing practices. As part of the settlement, AMR entered into a 3-year corporate integrity agreement with OIG.
- ▶ **Illinois**—As part of a joint effort, OIG, the FBI and United States Attorney’s Office for the Northern District of Illinois entered a consent judgment by which Royal Transportation Medi-Car, Inc., (Royal) and its owner agreed to pay the government and the State of Illinois \$468,000. From January 1998 through December 1999, Royal and its owner allegedly submitted, or caused to be submitted, improper claims for transportation services and billed excessive mileage for these services.

The Illinois collaboration also secured an order of default judgment totaling \$443,000 against DNB Transportation (DNB) and its owner. An audit conducted by the Illinois Department of Public Aid showed that from June 1997 through October 1998, DNB allegedly billed Medicaid for attendant services when the patients did not require such assistance; used improper procedure codes when billing Medicaid; and transported ambulatory Medicaid clients.

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### ***Contractors***

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- ▶ **Missouri**—General American Life Insurance Company, Inc., (General American), agreed to pay \$76 million to settle allegations of misconduct from 1988 through 1998 while acting as the Medicare Part B carrier. General American allegedly failed to process claims properly, then sub-

mitted false information to CMS regarding the accuracy and the timeliness with which it handled those claims. The company also allegedly breached its contractual obligations by failing to report errors identified in the quality assurance process; concealing its true error rate by deleting claims selected for review by CMS; and replacing deleted claim files with files which would not significantly affect their error rate and, ultimately, their standing within carrier performance rankings. Additionally, General American allegedly hid documents, altered other documents and falsified numerous reports mandated by CMS. The OIG did not require a corporate integrity agreement because General American has ceased to be a Medicare carrier.

- ▶ **Montana**—The former controller for a Medicare contractor was sentenced to 20 months in prison and ordered to pay \$235,000 in restitution for theft or embezzlement in connection with health care and tax evasion. Without authorization, the controller caused Medicare funds to be transferred to a specialized equipment leasing company for the purpose of securing an office equipment leasing agreement.

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### ***Practitioners***

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- ▶ An Indiana man was sentenced to 21 months in prison and ordered to pay \$1.9 million in restitution to persons who suffered injury as a result of his role in a conspiracy to defraud insurance carriers and cancer patients. The man worked as the business manager for a practitioner and operator of a medical center; the two aggressively marketed treatments not approved by FDA to terminally ill cancer patients. The man billed these treatments as if the patients received chemotherapy; he also created and submitted false documents to insurance companies to support the billings.
- ▶ Medical Center Emergency Services, P.C. (MCES) agreed to pay the government \$1.6 million to resolve *qui tam* allegations that it employed a billing agency that submitted upcoded claims for emergency room services to Medicare, Medicaid, TRICARE and the Federal Employee Health Benefits Program on MCES' behalf. The government further alleged that the billing agency routinely upcoded emergency services to an unwarranted Level IV service, which requires a detailed examination and history and medical decision making of moderate complexity. As part of the settlement, MCES agreed to enter into a 5-year corporate integrity agreement.
- ▶ A New York physician was sentenced to 37 months imprisonment and ordered to pay \$1.3 million in restitution for health care fraud. A licensed cardiologist, internist and certified acupuncturist, the physician billed for

nerve block injections when he actually performed acupuncture, a service not covered by Medicare or most insurance companies.

Also in New York, a nephrologist and his wife were sentenced for health care fraud and ordered to pay fines of \$20,000 and \$10,000, respectively. Prior to sentencing, the couple also paid restitution of \$88,000 each. From 1995 through 1998, the couple billed for multiple dialysis evaluations when the nephrologist actually only performed single dialysis evaluations.

### ***Kickbacks***

Individuals and entities that engage in unlawful referral or kickback schemes may be subject to criminal penalties under the federal criminal anti-kickback statute, civil monetary penalties under OIG's CMPL authority, and/or program exclusion under OIG's permissive exclusion authority. Additional statutory information can be found in Appendix F. The following are examples of kickback enforcement actions during this time period:

- ▶ ***Ohio***—A former CEO and owner of a mental health facility was sentenced in connection with his company paying kickbacks to several referral sources. The owner was sentenced to one year in prison and ordered to pay \$600,000 in restitution jointly with two other co-defendants. In addition one of the referral sources was ordered to pay \$12,000 in restitution for his role in the conspiracy. From 1995 through August 1998, the owner and his codefendants conspired to violate the anti-kickback statute by paying kickbacks to various sources to induce them to send out-of-state Medicare patients to the facility for treatment and by paying for the transportation of Medicare patients to the facility.
- ▶ ***Florida***—The following cases arise from OIG's ongoing investigation of kickbacks paid by a Florida clinical laboratory. To date, OIG has recovered approximately \$450,000 in civil penalties and damages from seven settlements.

A physician agreed to pay \$63,000 to settle his liability under the kickback provisions of the CMPL. The physician received kickbacks, disguised as monthly payments for space and medical equipment rental, from a clinical laboratory in return for his referral of Medicare beneficiaries.

The owner and operator of a Florida mobile diagnostic and respiratory care company agreed to pay \$25,000 to settle his liability under the CMPL's kickback provisions. This provider paid kickbacks disguised as space rental payments to several physicians for their referrals.

## **MEDICAID FRAUD CONTROL UNITS**

At present, 47 states and the District of Columbia have established Medicaid Fraud Control Units (MFCUs) that investigate and prosecute providers charged with defrauding the Medicaid program or persons charged with patient abuse and neglect. Three states—Idaho, Nebraska and North Dakota—have sought and received waivers from the requirement that all states operate MFCUs. The OIG annually certifies each MFCU as eligible to receive federal grant funds. During FY 2002, OIG provided oversight for and administration of approximately \$116.9 million in funds to the units.

- ▶ **Maine**—As a result of a joint investigation by OIG, the Maine MFCU and the FBI, McGovern’s Ambulance Service, Inc., and its owner agreed to pay \$300,000 to resolve their liability for submitting fraudulent claims to Medicare and Medicaid. The allegations included billing transports for nonmedical purposes, billing for services not rendered, billing for more mileage than was actually traveled and upcoding. In addition, the defendants were sentenced for health care fraud and other charges and ordered to pay \$730,000 in restitution. The company owner also was sentenced to over 4 years in jail.
  
- ▶ **Maryland**—As the result of a joint investigation by OIG and the Maryland MFCU, a registered nurse and owner of a dialysis clinic was sentenced to 5 years in jail, with all but 18 months suspended, and ordered to pay \$100,000 in restitution for Medicaid fraud and reckless endangerment. His clinic was fined \$300,000 for Medicaid fraud. From February 1999 through August 2001, the nurse failed to administer epogen, a synthetic hormone typically administered during dialysis, and falsified epogen administration flow sheets.
  
- ▶ **Washington**—As the result of a joint effort among OIG, the Washington MFCU and local law enforcement, a certified nursing assistant was sentenced after being convicted of a criminal assault violation. While employed by a nursing agency, the assistant assaulted a nursing home patient.

# *Public Health Agencies*

The activities conducted and supported by HHS public health agencies represent this country's primary defense against acute and chronic diseases and disabilities. These programs provide the foundation for the nation's efforts in promoting and enhancing the continued good health of the American people. These divisions within the department include the following:

National Institutes of Health (NIH)  
Food and Drug Administration (FDA)  
Centers for Disease Control and Prevention (CDC)  
Health Resources and Services Administration (HRSA)  
Indian Health Service (IHS)  
Agency for Toxic Substances and Disease Registry (ATSDR)  
Agency for Healthcare Research and Quality (AHRQ)  
Substance Abuse and Mental Health Services Administration (SAMHSA)

The OIG continues to examine policies and procedures throughout these agencies to determine whether proper controls are in place to guard against fraud, waste, and abuse. These activities include pre-award and recipient capability audits. This oversight work has provided valuable recommendations to program managers for strengthening the integrity of agency policies and procedures.

### **BIOTERRORISM PREPAREDNESS**

The OIG has continued its initiative to assess the security of a number of departmental assets against terrorist threats and the readiness and capacity of responders at all government levels to protect the public health in case of a bio-terrorist attack. Included in this initiative are reviews of the activities and programs of several departmental operating divisions, including CDC, NIH, and FDA. Using Department of Justice standards for physical security and additional criteria specifically focused on laboratory security, OIG reviewed the security measures in place at a number of the department's laboratories and at certain external laboratories that receive departmental funds. These efforts focused on laboratories that work with select agents because these substances could potentially be used in a bioterrorist attack. Further, OIG is assessing efforts by state and local health departments to detect and respond to bioterrorism and by CDC to rapidly deploy the National Pharmaceutical Stockpile. The OIG is also evaluating the integrity of CDC's vaccine procurement program and CDC's regulatory oversight of facilities that transfer and receive select agents. (Various CINs)

### **RYAN WHITE CLAIMS**

At HRSA's request, OIG assessed oversight and administration of Ryan White Care Act funds by Indiana and its terminated subgrantee. The OIG identified unallowable, unallocable, unapproved, and inadequately supported claims for the 3-year period ended March 31, 2001. Increased oversight and involvement by the state agency could have prevented or alleviated many of the conditions disclosed during the audit. The OIG set aside \$5.3 million in inadequately supported costs for HRSA's adjudication; recommended that the state refund more than \$784,000 in unallowable, unallocable, and unapproved costs; and recommended timelier audits and increased oversight of other subgrantees. State officials partially agreed. (A-05-01-00073)

### **CLINICAL TRIAL WEB SITES ♦♦**

In assessing the use of clinical trial web sites in fostering informed consent and the role of institutional review boards in overseeing the information on these web sites, OIG found that these sites are emerging as an important recruitment

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♦♦Performance measure. Details can be found in Appendix H.

strategy and show promise as a means of fostering informed consent. These web sites, however, sometimes provide inaccurate information about the clinical trial process, exclude key information in trial listings, and fail to disclose policies that address the use of personal information collected by the web site.

Based on these findings, OIG recommended that FDA and the Office for

**Most Internet sites reviewed provided valuable general & trial-specific information about clinical trials.**

**Of 22 general clinic trial sites reviewed:**

- 21 explain the importance of informed consent
- 16 describe the role of IRBs in protecting human rights
- 16 explain the overall purpose of clinical trials

**Of 110 trial-specific sites reviewed:**

- 90 provide eligibility criteria
- 80 provide a clear statement of the trial's purpose

Human Research Projects jointly provide guidance to institutional review boards regarding their responsibility for reviewing web sites, facilitate the adoption and use of voluntary standards for clinical trial web sites, and encourage clinical trial web sites to undergo periodic review by independent bodies. Currently, FDA is assessing the legal feasibility of requiring attestations

of good clinical practice compliance from investigators outside the U.S. when their data are submitted to the agency as part of an application. The FDA is also more broadly reviewing its requirements for the acceptance of foreign data in support of submitted applications.

(OEI-01-97-00198)

**FDA FIREARMS**

At the request of the President's Council on Integrity and Efficiency, OIG reviewed FDA procedures used to account for firearms issued to authorized personnel. The OIG concluded that FDA could account for its firearms and that its inventory operations had several features supporting accountability. While three FDA offices required the use of firearms, detailed inventory and custody records were maintained by a central office responsible for property management. (A-15-02-20003)

***EXCLUSIONS FOR HEALTH EDUCATION  
ASSISTANCE LOAN DEFAULTS***

Through the Health Education Assistance Loan (HEAL) program, HRSA guarantees commercial loans to students seeking education in health-related fields of study. The students are allowed to defer repayment of these loans until after they have graduated and begun to earn an income. Although the Department's Program Support Center (PSC) takes all steps that it can to ensure repayment, some loan recipients ignore their indebtedness.

After PSC has exhausted all efforts to secure repayment of these debts, it declares the individual in default. Thereafter, the Social Security Act permits, and in some instances mandates, exclusion from Medicare, Medicaid and all federal health care programs for nonpayment of these loans. During this 6-month period, 28 individuals and related entities were excluded as a result of PSC referral of their cases to OIG.

Individuals who have been excluded as a result of their default may enter into settlement agreements whereby the exclusion is stayed while they pay specified amounts each month to satisfy their debt. If they default on these settlement agreements, they can then be excluded until their entire debt is repaid, and they cannot appeal these exclusions. Some health professionals, upon being notified of their exclusion, immediately repay their HEAL debts.

After being excluded for nonpayment of their HEAL debts, a total of 1,711 individuals have taken advantage of the opportunity to enter into settlement agreements or completely repay their debts. This figure includes the 116 individuals who have entered into such a settlement agreement or completely repaid their debts during this reporting period. The amount of money being repaid through settlement agreements or through complete repayment totals over \$120 million. Of that amount, nearly \$9.4 million is attributable to this reporting period. In the following examples, each individual entered into a settlement agreement to repay the amount indicated:

- A New Jersey Podiatrist—\$330,000
- A Nevada Dentist—\$188,000
- A Pennsylvania Physician—\$165,000
- A Louisiana Osteopath—\$163,000

### **MISUSE OF PUBLIC HEALTH GRANT FUNDS**

- ▶ **Washington**—The comptroller for an organization providing counseling services was sentenced to 21 months imprisonment and ordered to pay restitution of \$116,000 for theft from a federally-funded program. An HHS grantee, the organization provided drug, alcohol and mental health counseling to adolescents and their families. Between 1996 and 1998, the comptroller engaged in an embezzlement scheme that ultimately caused the organization to close in 2001.
- ▶ **New York**—The owner/operator of a printing company was ordered to pay \$3,000 in delinquent taxes for tax fraud. Through his printing company, the man participated in a fraud scheme with the owner/operators of a company that received an HHS grant from SAMHSA. The owner of the printing company created fictitious invoices that inflated both the price and quantity of supplies and printing items received by the grantee from various vendors; the grantee then submitted these invoices for reimbursement under the SAMHSA contract.

### **FY 2001 FINANCIAL STATEMENT AUDITS ❖❖**

In support of its audit of the consolidated HHS-wide financial statements for FY 2001, OIG audited, through contracts with independent public accounting firms, the financial statements of the major operating divisions. Agency officials are taking corrective actions on most of the recommendations.

- **HRSA**: The accounting firm issued an unqualified opinion on the HRSA FY 2001 financial statements and noted no material weaknesses. (A-17-01-00005)
- **IHS**: The accounting firm issued an unqualified opinion on the IHS FY 2001 financial statements and noted two repeat material weaknesses: 1) the preparation and analysis of financial statements and 2) fund balance with Treasury transactions, timing of reconciliation procedures, and volume of differences. The IHS is commended for obtaining its first unqualified opinion on the consolidated statements of net cost, changes in net position, and financing and the combined statement of budgetary resources. (A-17-01-00006)

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❖❖Performance measure. Details can be found in Appendix H.

- ***SAMHSA***: The accounting firm issued an unqualified opinion on the SAMHSA financial statements and noted no material weaknesses.  
(A-17-01-00004)

# *Administrations for Children and Families and on Aging*

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The Administration for Children and Families (ACF) provides direction and funding for programs designed to promote stability, economic security, responsibility, and self-support for the nation's families. Some of the major programs include Temporary Assistance for Needy Families (TANF), Child Support Enforcement, Foster Care, Family Preservation and Support, Head Start, and the Child Care and Development Block Grant.

The OIG reviews those programs serving children and families. Reports have focused on ways to increase the efficient use of program dollars; to more effectively implement programs; to better coordinate programs among the Federal Government, and state and local governments; and to strengthen states' financial management practices.

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The Administration on Aging (AoA) awards grants to states for establishment of comprehensive community-based systems that assist the elderly in maintaining their independence and in remaining in their homes as long as possible. Socially and economically disadvantaged elderly and low-income minority elderly are targeted for assistance, including supportive services, nutrition services, education and training, low-cost transportation, and health promotion. The OIG has reported opportunities for program improvements to target the neediest for services, expand available financial resources, upgrade data collection and reporting, and enhance program oversight.

**RECRUITING AND RETAINING FOSTER PARENTS ❖❖**

In two related reports examining states’ efforts to recruit and retain foster parents, OIG found that recruitment methods are not focused on finding foster parents who are willing and able to care for the most challenging children. At the same time, states are underutilizing foster parents themselves as one of their most effective recruitment tools; their network of friends and associates might be more

Placement Setting	Children in Placement	
	Percent of Foster Children	Number of Foster Children
Foster Family Homes (Non-Relative)	47	274,100
Foster Family Homes (Relative)	26	151,864
Institutions	10	57,590
Group Homes	8	46,279
Pre-Adoptive Homes	4	22,484
Trial Home Visits (with own families)	2.7	15,818
Runaway and Homeless Youth Shelters	1.4	7,886
Supervised Independent Living Facilities	.9	4,979
<b>Total</b>	<b>100</b>	<b>581,000</b>

ready and able to serve as foster parents than many who are recruited through more general methods.

Once recruited, retention often becomes difficult. Foster parents experience limited case-worker support and need more help obtaining services for themselves and their foster children. They desire greater opportunities to voice their concerns. Poor public perceptions of foster care and cumbersome requirements have a negative impact on recruitment, and foster parents are troubled by false allegations of abuse.

The OIG also found that states are unable to measure the success of their recruitment and retention efforts.

The ACF agreed with OIG’s

recommendations including, among other things, diligent recruitment and improved public perception of foster care. (OEI-07-00-00600, OEI-07-00-00601)

**PROMOTING SAFE AND STABLE FAMILIES PROGRAM**

A five-state review of the Promoting Safe and Stable Families program found that states did not use \$66.5 million, or 34 percent, of the \$197.7 million

❖❖Performance measure. Details can be found in Appendix H.

available to them in FYs 1994 through 1999. The unobligated funds could not be used by other states because the program statute did not provide reallocation authority; however, during the review, ACF proposed legislation to provide reallocation authority which was signed into law in December 2001. The ACF generally concurred with OIG's recommendations concerning program monitoring and grant fund reallocation. (A-06-02-00011)

### ***WORKING WITH HARD-TO-EMPLOY TANF RECIPIENTS***

This report examines state strategies for working with hard-to-employ (i.e. currently on welfare, for purposes of this report) Temporary Assistance for Needy Family (TANF) recipients who have at least one significant barrier to employment. Eight barriers, such as substance abuse, mental health issues, and physical disabilities, were considered. Interviews with state officials indicate that states rely on a variety of strategies to identify barriers, build service partnerships with appropriate agencies and refer recipients to these partnerships. Although states have structured their TANF policies to provide additional flexibility for recipients with barriers, challenges remain with respect to recipients with multiple barriers and tracking and evaluating what works for these populations.

The OIG recommended that ACF encourage states to create and expand innovative programs and to strengthen tracking systems of program success. The ACF concurs and will continue in its efforts to assist states in dealing with this population. (OEI-02-00-00630)

### ***REFUNDING AFDC OVERPAYMENTS***

States are required to pursue Aid to Families with Dependent Children (AFDC) overpayments made before October 1, 1996, and to make appropriate refunds to the Federal Government for the amounts collected. Collections of overpayments occurring after that date are to be used to offset Temporary Assistance for Needy Families expenditures in the year collected. As part of a nationwide initiative, these reviews were conducted to determine whether 11 states, as well as New York City and San Bernardino County, California, properly refunded the federal share of AFDC overpayments.

The OIG found that, generally, systems were in place to identify and collect overpayments. However, while Montana refunded more than necessary, the other states did not refund to the government its proportionate share. The OIG recommended that a total of \$88.8 million be returned to the Federal Government. New York, Connecticut, Ohio, Utah, Tennessee, Arkansas, Oklahoma, and New

Mexico agreed to refund \$68.1 million collectively. California will address the findings at a later date. Asserting that they acted in good faith, Wisconsin, Missouri, and Iowa disagreed with OIG's findings.

(A-01-01-02509; A-02-01-02000; A-04-01-00009; A-05-01-00101; A-05-02-00031; A-06-02-00028; A-06-02-00029; A-06-02-00030; A-07-02-03012; A-07-02-03014; A-08-02-03003; A-08-02-03004; A-09-01-00103)

## **CHILD SUPPORT ENFORCEMENT**

The OIG has made the detection, investigation and prosecution of absent parents who fail to pay court-ordered child support a priority. The OIG continues to work with the Office of Child Support Enforcement (OCSE), DOJ, U.S. Attorneys' Offices, U.S. Marshals Service and other federal, state and local partners to develop programmatic and operational procedures to expedite the collection of child support and to bring to justice those who willfully disregard their obligations.

Since 1995, OIG has opened 1,881 investigations of child support cases nationwide, which have resulted in 607 convictions and court-ordered criminal restitution and settlements of over \$32.9 million.

### ***Task Forces***

In 1998, OIG and OCSE initiated "Project Save Our Children," a criminal child support initiative made up of multiagency, multijurisdictional investigative task forces. The task forces are designed to identify, investigate and prosecute egregious criminal nonsupport cases both on the federal and state levels through the coordination of law enforcement, criminal justice and child support office resources. *(A table of the task force regions appears on the next page.)*

Central to the task forces are the screening units located in each task force region and staffed by analysts and auditors from OIG and OCSE. The units receive child support cases from the states, conduct preinvestigative analyses of these cases through the use of databases, and then forward the cases to the investigative task force units where they are assigned and investigated. The task force approach streamlines the process by which the cases best suited for criminal prosecution are identified, investigated and brought to fruition.

At this point, the task force units have received over 5,113 cases from the states. As a result of the work of the task forces, 276 federal arrests have been executed and 192 individuals sentenced. The total ordered amount of restitution related to federal investigations is over \$8.9 million. There have been 314

arrests at the state level and 279 convictions or civil adjudications to date, resulting in over \$10.8 million in restitution being ordered.

<b>Task Force Regions</b>	<b>Task Force Headquarters</b>	<b>Task Force States</b>
Mid-Atlantic	Baltimore, Maryland	Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia
Midwest	Columbus, Ohio	Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
Northeast	New York, New York	New Jersey, New York, Puerto Rico
Southeast	Atlanta, Georgia	Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee
Southwest	Dallas, Texas	Arkansas, Louisiana, New Mexico, Oklahoma, Texas
West Coast	Sacramento, California	Arizona, California, Hawaii, Nevada
New England	Boston, Massachusetts	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Great Plains	Topeka, Kansas	Iowa, Kansas, Missouri, Nebraska, North Dakota, South Dakota
Rocky Mountains	Denver, Colorado	Colorado, Montana, Utah, Wyoming
Pacific North	Olympia, Washington	Alaska, Idaho, Oregon, Washington

### ***Intensive Child Support Operation***

In a unique enforcement operation, OIG and OCSE organized and led the single largest crackdown on child support defaulters since initiating Project Save Our Children four years ago. As the result of this two-day, coordinated sweep by OIG, the U.S. Marshals Service, and state and local police, 70 of the nation’s most wanted deadbeat parents were arrested at various locations in 29 states, the District of Columbia and Puerto Rico. All those arrested were either under federal indictment or the subjects of criminal complaints for willful failure to pay court-ordered child support. In addition to the 70 arrested, authorities continue to actively pursue 32 other defaulters for whom arrest warrants or summonses were issued as part of the enforcement action. The 102 defaulters collectively owe more than \$5 million in child support, and many of them fled across state lines and switched jobs multiple times to avoid making payments. Individually, their overdue obligations range from \$7,500 to \$297,000, and all of them are at least a

year late in their payments. The defendants were selected for enforcement action because they were among the most egregious offenders out of the cases referred by state child support enforcement agencies to federal authorities for investigation and prosecution.

### ***Additional Enforcement***

During this period, OIG investigations of child support cases, nationwide, resulted in 78 convictions and court-ordered criminal restitution of over \$3.3 million. Examples of the federal arrests, convictions and sentences resulting from OIG's enforcement work, both inside and outside the task force regions, include the following:

- ▶ ***Mississippi***—A physician was sentenced to one year incarceration, one year supervised release and ordered to pay \$170,000 in restitution. The physician, who has worked at several hospitals and clinics in Mississippi, has five children who reside with two former wives in Illinois.
- ▶ ***South Dakota***—A man was sentenced to 18 months confinement and ordered to pay \$126,000 in restitution and to remain current in his child support obligations. Since the original child support order was filed in 1989, the man has maintained a variety of employment positions.
- ▶ ***Wisconsin***—A man was sentenced to 21 months imprisonment, 1 year supervised release and ordered to pay \$85,000 in restitution. He was also ordered to be employed as a condition of his release and to cooperate fully with the state child support agency. The man, who at one time worked in law enforcement, failed to pay support for his three children.
- ▶ ***Nebraska***—A man was sentenced to 6 months home confinement, 5 years probation and ordered to pay \$74,000 in restitution. He worked as an auto repossession broker.
- ▶ ***South Carolina***—A man was sentenced to 18 months incarceration, 3 years supervised release and ordered to pay \$55,000 in restitution for unlawful possession of a controlled substance, false statements in an application for a passport and failure to pay child support. When initially arrested and charged with fraud in connection with identification documents and false statements in application and use of passports, investigators with the U.S. Department of State found that the man had also failed to pay child support for his 11-year-old daughter in Oklahoma.
- ▶ ***Ohio***—A former doctor of osteopathic medicine was sentenced to 20 months in prison, 2 years supervised release and ordered to pay a

\$620 special assessment. After a jury convicted him in April on eight counts of failure to pay child support, the man paid full restitution and advance child support payments totaling \$55,000 to the custodial parent.

- *Alaska*—A woman was sentenced to 5 years probation and ordered to pay \$18,000 in restitution. She never made a support payment for her three children who reside with their father in Michigan.

### ***INSURANCE INTERCEPT PROGRAM*** ❖❖

These reviews assessed two innovative programs for intercepting insurance claim payments to noncustodial parents with child support debts. The OIG estimated that Massachusetts collected \$10.6 million from insurance payments to noncustodial parents from April 1999 through September 2001, thereby reducing outstanding child support by about 22 percent, increasing financial support to children by \$5.4 million, and recovering \$4.4 million in public assistance (federal share: \$2.2 million). Similar results were achieved in Rhode Island. Average collections per case were \$3,200 in Massachusetts and \$3,400 in Rhode Island. Startup and annual operating costs were minimal in both states. The insurance intercept program can also help states locate noncustodial parents.

The OIG recommended that ACF initiate a national program or encourage other states to implement a similar program. The ACF supports implementation of a nationwide system to assist in offsetting insurance proceeds for child support arrearages. (A-01-02-02501; A-01-01-02508)

### ***COMMUNITY SERVICES ECONOMIC DEVELOPMENT GRANT*** ❖❖

At the department's request, OIG performed a limited-scope review of a corporation's administration of an Office of Community Services (OCS) economic development grant. The review found that the corporation did not meet the grant objectives of creating a community-owned restaurant to provide employment to 30 individuals. Also, the grant funds, which totaled \$250,000, were not used as outlined in the OCS-approved grant.

The OIG recommended that OCS recover the \$250,000 and that the corporation evaluate its ability to properly control and account for federal funds before submitting future HHS grant proposals. Corporation officials generally disagreed with the findings and recommendations. (A-04-02-00010)

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❖❖Performance measure. Details can be found in Appendix H.

**MISUSE OF ACF GRANT FUNDS**

- **North Carolina**—An employee of the state’s Department of Health and Human Services was ordered to pay \$274,000 in restitution and a \$250,000 criminal fine for obstruction of justice. The employee caused the state to submit false claims to the HHS Title IV-E program for expenses incurred by an unrelated organization with which she had a personal affiliation. The employee also attempted to impede the federal investigation by concealing the fact that she had federal grant funds for foster care and adoptive children paid either to herself or the organization.
  
- **Louisiana**—Two individuals were jointly ordered to pay \$54,000 in restitution for false claims. As owners of three day care facilities, the individuals submitted false claims to the Louisiana Department of Social Services for Child Care and Development Program services funded through an HHS block grant. The facility billed for services provided to children who were not actually present at the day care facilities or who were present only part time when full-time services were claimed.

**FY 2001 FINANCIAL STATEMENT AUDIT:  
ADMINISTRATION ON AGING ❖❖**

In support of its audit of the consolidated departmentwide financial statements for FY 2001, OIG contracted with an independent accounting firm to audit the Administration on Aging’s financial statements. The accounting firm issued an unqualified opinion on the FY 2001 financial statements and noted no material weaknesses. (A-17-01-00019)

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❖❖Performance measure. Details can be found in Appendix H.

# *General Oversight*

The Office of the Assistant Secretary for Budget, Technology and Finance (ASBTF) is responsible for developing and executing the Department of Health and Human Services' (HHS) budget; ensuring that HHS performance measurement and reporting are in compliance with the Government Performance and Results Act; establishing and monitoring departmental policy for financial management (including debt collection, audit resolution, cost policy, and financial reporting); and developing and monitoring HHS information technology policy (including IT security). The Assistant Secretary is the department's Chief Financial Officer and oversees the department's Chief Information Officer. The department also has the responsibility, by virtue of the magnitude of its funding, to negotiate the payment rates and methods that many outside entities, such as state and local governments, charge for administering HHS and other federal programs.

The Office of the Assistant Secretary for Administration and Management (ASAM) is responsible for HHS policies regarding human resources, grants, and acquisitions management. This office also oversees the Program Support Center, which provides a range of administrative services, such as human resources, financial management, and administrative operations.

The OIG has oversight responsibility for these activities at the departmental level. A related major responsibility flows from Office of Management and Budget (OMB) Circular A-133, under which HHS is the cognizant agency to audit the majority of federal funds awarded to major research schools, state and local government cost allocation plans, and separate indirect cost plans of state agencies and local governments. Also, OIG oversees the work of nonfederal auditors of federal money at some 6,700 entities, such as community health centers and Head Start grantees, as well as at state and local governments, colleges and universities, and other nonprofit organizations. The OIG is also responsible for auditing the department's financial statements.

**RESULTS ACT** ❖❖

The Government Performance and Results Act (GPRA) of 1993 mandates that federal agencies establish strategic planning and prepare annual performance plans, beginning with FY 1999. The annual performance plans set measurable goals for the year's accomplishments, and annual reports compare actual performance with those goals. The OIG's work focuses on measures related to mission-critical issues and areas at high risk of fraud, waste, and abuse and includes assessments of data collection methods and controls over the systems that produce performance data. An ongoing objective of OIG's audits, inspections, and investigations is to identify performance results and recommend improvements.

The OIG's continuing payment error rate reviews at CMS relate directly to assessment of CMS-generated financial performance data. The CMS uses OIG's annual estimate of the Medicare fee-for-service error rate as a basis for setting performance goals and for measuring performance. For FY 2001, OIG reported an estimated 6.3 percent error rate. The CMS goal is to reduce this rate to 5 percent by 2002.

In addition, OIG reviewed selected Administration for Children and Families (ACF) performance measures in the FY 2000 GPRA report to determine the reliability of the performance results reported and to evaluate the process used to verify this information. The review covered 12 performance measures for 3 ACF programs: Developmental Disabilities, Head Start, and the Low Income Home Energy Assistance Program. In summary, OIG found that:

- Reported results for 11 of the 12 measures agreed with ACF supporting documentation;
- Results for the 12<sup>th</sup> measure were overstated; however, the performance target was still met based on corrected results; and
- ACF program staff conducted data verification activities as described in the FY 2000 performance report.

Although OIG does not plan to make specific recommendations based on the review, ACF program offices may benefit by establishing policies and procedures for ensuring that reported results are reliable. These policies could include identifying the actions that program staff should take and documenting significant differences between targeted and reported results or significant variances from year to year for a particular grantee. (A-12-01-00061)

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\*❖Performance measure. Details can be found in Appendix H.

***FY 2001 FINANCIAL STATEMENT AUDIT:  
PROGRAM SUPPORT CENTER ❖❖***

In support of its audit of the consolidated HHS-wide financial statements for FY 2001, OIG contracted with an independent accounting firm to audit the Program Support Center's financial statements. The accounting firm issued an unqualified opinion on the center's FY 2001 financial statements and noted no material weaknesses. (A-17-01-00007)

***NONFEDERAL AUDITS***

The OMB Circular A-133 establishes audit requirements for state and local governments, colleges and universities, and nonprofit organizations receiving federal awards. Under this circular, covered entities are required to have an annual organization-wide audit which includes all federal money they receive. These annual audits are conducted by nonfederal auditors, such as public accounting firms and state auditors. As cognizant auditor, OIG reviews the quality of these audits and assesses the adequacy of the entity's management of federal funds. In the second half of FY 2002, OIG's National External Audit Review Center reviewed about 924 reports that covered \$1.05 trillion in audited costs. Federal dollars covered by these audits totaled \$322.2 billion, about \$148.5 billion of which was HHS money.

The OIG's oversight of nonfederal audit activity not only provides department managers with assurances about the management of federal programs but also identifies any significant areas of internal control weakness, noncompliance, and questioned costs that require formal resolution by federal officials. By taking a proactive stance, OIG identifies entities for high-risk monitoring and any trends that could indicate problems in HHS programs. In addition, OIG profiles non-federal audit findings of a particular program or activity over time to identify systemic problems. As a further enhancement of audit quality, OIG provides training and technical assistance to grantees and the auditing profession.

To rely on the work of nonfederal auditors, OIG maintains a quality control review process which assesses the nonfederal reports received and the audit work that supports selected reports. The nonfederal audit reports reviewed and issued during this reporting period fall into the following categories:

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❖❖Performance measure. Details can be found in Appendix H.

<i>Reports issued:</i>	
<i>Without changes or with minor changes</i>	<i>878</i>
<i>With major changes</i>	<i>29</i>
<i>With significant inadequacies</i>	<i>17</i>
<i>Total</i>	<i>924</i>

The 924 reports included recommendations for HHS program officials to take action on cost recoveries totaling \$10.5 million, as well as 4,363 recommendations for improving management operations. In addition, these audit reports provided information for 84 special memoranda which identified concerns for increased monitoring by departmental management.

### ***RESOLVING RECOMMENDATIONS***

The tables that appear on the following pages are provided in accordance with section 5 of the Inspector General Act and indicate the dollar value of actions taken on OIG recommendations.

In Table 1, “Dollar Value Questioned” costs are those challenged because of violation of law, regulation, grant conditions, etc. “Dollar Value Unsupported” costs are those not supported by adequate documentation. Table 2 summarizes recommendations that funds be put to better use through cost avoidances, budget savings, etc. These costs are separate from the amount ordered or returned as a result of OIG investigations.

**Table 1: Reports With Questioned Costs**

<i>Reports</i>	<i>Number of Reports</i>	<i>Dollar Value Questioned</i>	<i>Dollar Value Unsupported</i>
<b>Section 1</b>			
For which no management decision had been made by the beginning of the reporting period <sup>1</sup>	474	\$1,247,792,000	\$175,915,000
Issued during the reporting period	138	\$419,040,000	\$98,054,000
<b>Total Section 1</b>	<b>612</b>	<b>\$1,666,832,000</b>	<b>\$273,969,000</b>

<b>Section 2</b>			
For which management decision was made during the reporting period <sup>2,3</sup>			
Disallowed costs		\$177,558,000	\$32,251,000
Costs not disallowed		\$38,000,000	\$90,000
<b>Total Section 2</b>	<b>175</b>	<b>\$215,558,000</b>	<b>\$32,341,000</b>

<b>Section 3</b>			
For which no management decision had been made by the end of the reporting period			
<b>Total Section 1 minus Total Section 2</b>	<b>437</b>	<b>\$1,451,274,000</b>	<b>\$241,628,000</b>

<b>Section 4</b>			
For which no management decision was made within 6 months of issuance <sup>4</sup>	<b>309</b>	<b>\$1,098,343,000</b>	<b>\$109,834,000</b>

**Table 2: Funds Recommended to Be Put to Better Use**

<i>Reports</i>	<i>Number of Reports</i>	<i>Dollar Value</i>
<b>Section 1</b>		
For which no management decision had been made by the beginning of reporting period <sup>1</sup>	48	\$8,965,518,000
Issued during the reporting period	7	\$5,825,000
<b>Total Section 1</b>	<b>55</b>	<b>\$8,971,343,000</b>

<b>Section 2</b>		
For which management decision was made during the reporting period		
Value of recommendations that were agreed to by management		
Based on proposed management action	4	\$569,857,000
Based on proposed legislative action	1	\$100,000,000
Value of recommendations that were not agreed to by management		0
<b>Total Section 2</b>	<b>5</b>	<b>\$669,857,000</b>

<b>Section 3</b>		
For which no management decision had been made by the end of the reporting period <sup>2</sup>		
<b>Total Section 1 minus Total Section 2</b>	<b>50</b>	<b>\$8,301,486,000</b>

**LEGISLATIVE AND REGULATORY  
REVIEW AND DEVELOPMENT*****Review Functions***

Section 4(a) of the Inspector General Act of 1978 requires that the Inspector General review existing and proposed legislation and regulations and make recommendations in this report concerning the impact on the economy and efficiency of the administration of the department's programs and on the prevention of fraud and abuse. In reviewing regulations and legislative proposals, OIG uses as the primary basis for its comments the audits, inspections, investigations and other activities highlighted in this and previous semiannual reports.

***Development Functions***

The OIG is responsible for the development and public announcement of a variety of sanction regulations addressing civil money penalty and program exclusion authorities administered by the Inspector General, as well as advisory opinions and safe harbor regulations related to the anti-kickback statute. During this reporting period, OIG:

- Published proposed rulemaking to expand the existing safe harbor for certain waivers of beneficiary coinsurance and deductible amounts to benefit the policyholders of Medicare SELECT supplemental insurance. The proposed safe harbor is designed to protect waivers of coinsurance and deductible amounts under Part A or Part B of the Medicare program owed by beneficiaries covered by a Medicare SELECT policy issued in accordance with section 1882(t)(1) of the Social Security Act (the Act), if the waiver is in accordance with a price reduction agreement covering such policy-holders between the Medicare SELECT issuer and the provider or supplier offering the waiver. This proposed rule was published in the *Federal Register* in September (67 FR 60202, September 25, 2002).
- Developed draft proposed rulemaking to revise OIG's authority to propose the imposition of civil monetary penalties and assessments, by reorganizing and simplifying existing regulatory text and eliminating obsolete references contained in the current regulations. Among the proposed revisions, this rule would establish separate subparts within 42 CFR part 1003 for various categories of violations; modify the current definition for the term "claim;" update various references to managed care organization authorities; and clarify the application of section 1140 of the Act with respect to the misuse of certain departmental symbols, emblems or names through Internet and e-mail communications.

- Coordinated regulatory development efforts with the Centers for Disease Control and Prevention with regard to implementation of the Public Law 107-88, the Public Health Security and Bioterrorism Act. Specifically, OIG's portion of this interim final rulemaking will amend 42 CFR part 1003 by addressing new CMPs for violations of section 351A of the Public Health Service Act with respect to the control or transfer of listed biological agents and toxins.

Also, during this period, OIG developed and published the following two *Federal Register* notices:

- A draft Compliance Program Guidance (CPG) for Ambulance Suppliers (67 FR 39015; June 6, 2002). Through this draft, OIG set forth its general views on the value and fundamental principles of ambulance industry CPG and the specific elements that ambulance providers and suppliers should consider when developing a CPG initiative.
- A solicitation notice seeking information and recommendations for revising the CPG for the hospital industry (67 FR 41433; June 18, 2002).

### ***EMPLOYEE FRAUD AND MISCONDUCT***

Most of the persons employed by HHS are dedicated, honest civil servants. Occasionally, however, individuals violate their fiduciary responsibilities. The OIG conducts or oversees investigations of serious allegations of wrongdoing by department employees, as in the following example:

- ***Illinois*** —A former CMS employee was sentenced to 4 months imprisonment and ordered to pay \$39,000 in restitution for wire fraud and false claims. The employee engaged in a scheme to benefit from preparing false federal income tax returns. Part of her scheme involved filing tax returns for individuals without their knowledge or consent. In these instances, she had the refunds mailed to her residence or electronically transferred into bank accounts she fraudulently opened. The employee used her government computer to prepare and electronically file some of the tax returns.

### ***INVESTIGATIVE PROSECUTIONS***

During this semiannual reporting period, OIG investigations resulted in 267 successful criminal actions. Also during this period, 577 cases were presented for

criminal prosecution to DOJ and, in some instances, to state and local prosecutors. Criminal charges were brought by prosecutors against 316 individuals and entities.

In addition to terms of imprisonment and probation imposed in the judicial processes, over \$709.8 million was ordered or returned as a result of OIG investigations during this reporting period. Civil settlements from investigations resulting from audit findings are included in this figure.

### ***PROGRAM FRAUD CIVIL REMEDIES ACT***

The Program Fraud Civil Remedies Act (PFCRA), 31 U.S.C. §§ 3801-3812, authorizes the imposition of civil monetary penalties and assessments against anyone who makes a false, fictitious, or fraudulent claim or written statement to a federal agency. It was modeled after the Civil Monetary Penalty Law (42 U.S.C. 1320a-7a), which is applicable to false or otherwise improper claims presented to Medicare, Medicaid or other federal health care programs.

Under PFCRA, a person who presents a false, fictitious or fraudulent claim to a federal agency may be subject to a civil monetary penalty of up to \$5,000 per claim or statement, as well as an assessment of up to double the amount of each claim falsely made. The OIG is responsible for investigating allegations of false claims and statements presented to the department.

No matters were specifically referred for administrative action solely under PFCRA during FY 2002. While cases are routinely analyzed for potential action under PFCRA, at HHS the availability of other criminal, civil and administrative remedies often renders unnecessary the referral of cases for action solely under PFCRA. However, OIG does assert its administrative authority under PFCRA as one basis in settlement agreements, in which OIG is a party, that resolve cases arising under the False Claims Act and other federal statutes. In addition, as part of these settlements, the defendant is released from liability under PFCRA.





*Appendices*



**Appendix A**  
**Savings Achieved through Policy and Procedural Changes Resulting from Audits,  
Investigations and Inspections**  
**April 1, 2002, through September 30, 2002**

The following schedule highlights savings resulting from Office of Inspector General (OIG) efforts to prevent unnecessary obligations for expenditures of agency funds or to improve agency systems and operations. These achievements depend greatly on the contributions of others, such as partners within the department and elsewhere. The amounts shown represent funds or resources that will be used more efficiently as a result of documented measures taken by the Congress or by management in response to OIG audits, investigations and inspections, including: actual reductions in unnecessary budget outlays; deobligations of funds; reductions in costs incurred or pre-award grant reductions from agency programs or operations; and reduction and/or withdrawal of the federal portion of interest subsidy costs on loans or loan guarantees, or insurance or bonds.

Legislative savings are annualized amounts based on Congressional Budget Office (CBO) estimates consistent with CBO savings. In keeping with OIG policy, savings from the Medicare provisions of the Balanced Budget Act (BBA) of 1997 were adjusted downward to reflect CBO estimates for related provisions of the Balanced Budget Refinement Act (BBRA) of 1999. Administrative savings are calculated by OIG using departmental figures, where available, for the year in which the change is effected or for multiple years, if applicable.

Total savings from these sources amount to \$7,921 million for this period.

<b>OIG Recommendation</b>	<b>Implementing Action</b>	<b>Savings (millions)</b>
<b>Centers for Medicare and Medicare Services</b>		
<b>Medicare Home Health Payments:</b> Restructure the payment system for home health care to eliminate inappropriate incentives which unnecessarily increase cost and utilization; prevent unscrupulous providers from gaining entry into the program; and improve program controls, such as eligibility determinations and approval of plans of care and services. (OEI-04-93-00260; OEI-09-96-00110; CIN: A-04-96-02121)	Chapter I of Subtitle G of the BBA of 1997 (as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1998), which pertains to home health benefits, addresses OIG's concerns regarding the need to restructure and control the payment system for these services. For example, it mandates that a prospective payment system be developed and that the total payments in fiscal year (FY) 2000 be equal to the amount that would have been paid under the prior system if cost limits were reduced by 15 percent. It also eliminates periodic interim payments to home health agencies.	\$4,500
<b>Medicare Indirect Medical Education:</b> The Centers for Medicare and Medicaid Services (CMS) should base the indirect medical education adjustment factor on the level supported by CMS' empirical data. (CIN: A-07-88-00111)	Section 4621 of the BBA (as amended by the BBRA of 1999) reduced the indirect teaching adjustment factor from 7.7 percent in FY 1997 to 7.0 percent in FY 1998; 6.5 percent in FY 1999; 6.0 percent in FY 2000; and 5.5 percent in FY 2001 and thereafter.	\$1,780

Appendix A

<p><b>Medicaid Enhanced Payments to Local Providers:</b> The CMS should reconsider capping the aggregate upper payment limit at 100 percent for all facilities rather than the 150 percent allowance for non-state-owned government hospitals. (CIN: A-03-00-00216)</p>	<p>On January 18, 2002, CMS issued a final rule that modified the Medicaid upper payment limit (UPL) provisions to remove the 150 percent UPL for services furnished by non-state government-owned or operated hospitals. The rule became effective on May 15, 2002.</p>	<p>\$800</p>
<p><b>Graduate Medical Education Payments:</b> The CMS should reevaluate Medicare’s policy of paying graduate medical education (GME) costs for all physician specialties and should consider submitting legislation to reduce Medicare’s investment in GME to arrive at a more representative and accurate sharing of GME costs. (CIN: A-06-92-00020)</p>	<p>Sections 4623 and 4626 of the BBA provided for limits in the number of residents counted for purposes of Medicare GME payments and offered payments for voluntary reductions in the number of residents to limit Medicare’s share of GME costs.</p>	<p>\$310</p>
<p><b>Medicare Disproportionate Share:</b> The disproportionate share adjustment should be reduced, if not eliminated, without redistribution of the funds to prospective payment system hospitals. (CIN: A-04-87-01004)</p>	<p>Section 4403 of the BBA provided for the reduction of disproportionate share payments that hospitals would otherwise receive by 1 percent in FY 1998, 2 percent in FY 1999, 3 percent in FY 2000, 4 percent in FY 2001, 5 percent in FY 2002 and 0 percent thereafter.</p>	<p>\$210</p>
<p><b>Hospice Certification:</b> The CMS should restructure hospice benefit policies to curb inappropriate growth in the program, particularly with regard to the fourth benefit period. (OEI-05-95-00250; CIN: A-05-96-00023)</p>	<p>Sections 4441-4449 of the BBA of 1997 contained provisions to control hospice payments and practices, such as replacing the current unlimited fourth benefit period with an unlimited number of 60-day benefit periods (each requiring recertification).</p>	<p>\$70</p>
<p><b>Fraud and Abuse Provisions of the Balanced Budget Act:</b> Require durable medical equipment (DME) suppliers and home health agencies (HHAs) to provide Social Security numbers (SSNs) and employee identification numbers (OEI-04-96-00240 &amp; OEI-09-96-00110); refuse to enter into a provider agreement with any HHA whose owners or principals have prior criminal records or are the relatives of owners of a provider that had defrauded the Medicare program (OEI-09-96-00110); allow CMS to apply “inherent reasonableness” <i>continued—</i></p>	<p>Subtitle D of the BBA contained a number of provisions that corresponded to and were supported by OIG work. For example, the BBA authorized the Secretary to collect SSNs and employer identification numbers from entities under Medicare, Medicaid and Title V; authorized the Secretary to refuse to enter into contracts with physicians or suppliers that have been convicted of felonies; authorized the exclusion of entities owned or controlled by the family or household members of excluded individuals; authorized CMS to make inherent reasonableness adjustments up to 15 percent to all Part B services except physician services; authorized up to five demonstration projects to be completed by December 31, 2002, (one must be oxygen and oxygen equipment) which can have multiple sites,</p>	<p>\$60</p>

<p><b>Fraud and Abuse Provisions of the Balanced Budget Act (continued—)</b> provisions when assessing the appropriateness of Medicare payments (OEI-03-94-00392); authorize competitive bidding as a means of providing Medicare services (OEI-03-94-00021; OEI-06-92-00866; OEI-03-96-00230); and require DME suppliers and HHAs to post surety bonds as a condition of participation. (OEI-04-96-00240; OEI-09-96-00110). Also, clarify which general and administrative and fringe benefit costs at hospitals and HHAs are related to patient care; specifically, distinguish between employee benefits and/or perquisites to entertainment and patient care, and specify that cost of entertainment, goods or services for personal use, alcohol, all fines and penalties and associated interest, dues, and membership costs associated with civic and community organizations are not allowable. (CINs: A-03-92-00017, A-04-93-02067)</p>	<p>to allow competitive bidding; and prohibited “reasonable cost” payments for items such as entertainment, gifts and donations, education expenses and personal use of automobiles. The BBA also required DME suppliers, HHAs and others to post surety bonds of a minimum of \$50,000.</p>	
<p><b>Hospital Sales:</b> The CMS should eliminate the requirement that Medicare adjust for gains and losses when hospitals undergo changes of ownership. (OEI-03-96-00170)</p>	<p>Section 4404 of the BBA eliminated the requirement that Medicare make adjustments by setting the Medicare capital asset sales price equal to the net book value.</p>	<p>\$60</p>
<p><b>Rural Health Clinics:</b> The oversight and functioning of the current cost reimbursement system should be improved by implementing caps on provider-based rural health clinics (RHCs) and allowing states to do so, or finding other ways to make reimbursement between provider-based and independent RHCs more equitable. In addition, the certification process should be modified to increase state involvement and ensure more strategic placement of RHCs. Recertification should be required of RHCs within a specific time limit (for example 5 years), applying new criteria to document the need and impact on access. (OEI-05-94-00040)</p>	<p>Section 4205 of the BBA extended the per-visit payment limits to provider-based clinics and stipulated that the shortage area requirements designation be reviewed triennially.</p>	<p>\$50</p>

*Appendix A*

<p><b>Medicaid Expenditures for Supplementation Payments to County Nursing Homes:</b>          Pennsylvania should: 1) discontinue the practice of overclaiming federal matching funds by overreporting supplementation payments and 2) refund \$89.5 million in federal matching funds for overclaimed supplementation payments in state fiscal years 1997 through 1999. (CIN: A-03-00-00211)</p>	<p>The CMS issued a disallowance letter for \$125.3 million which includes the \$89.5 million in federal matching funds recommended for refund and an additional \$35.8 million overclaimed supplementation payments from June 30, 2000 to June 30, 2001.</p>	<p>\$35.8</p>
<p><b>Payments for Ambulance Services:</b>          The CMS should seek legislative authority to develop a fee schedule for ambulance transportation and examine the inherent reasonableness of current allowable charges. (OEI-05-95-00300)</p>	<p>Section 4531 of the BBA of 1997 made interim reductions in ambulance payments by limiting the allowed rate of increase and mandated the establishment of a fee schedule by January 1, 2000. Such fee schedule is to be set so that aggregate payments are reduced by 1 percent.</p>	<p>\$10</p>

*Administration for Children and Families*

<p><b>Availability of Health Insurance for Title IV-D Children:</b>          The OIG recommended that the State of Connecticut either: 1) implement policies and procedures to require noncustodial parents (NCPs) to pay all or part of the Medicaid costs for their dependent children or 2) establish a statewide health insurance plan that provides reasonably priced comprehensive coverage for children, with costs paid by NCPs. (CIN: A-01-97-02506)</p>	<p>The BBA of 1997 established Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP), to enhance Medicaid coverage provided to children and allow states to create insurance options for families who exceed Medicaid resource and income limits. Connecticut received CMS approval in April 1998 to initiate a child health program. Under Connecticut law, applicants include noncustodial parents under court orders to provide health insurance.</p>	<p>\$5.7</p>
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*Various Operating Divisions*

<p><b>Results of Investigations:</b>          In addition to any restitution, fines, settlements or judgments, or other monetary amounts resulting from successful investigations, additional monetary losses are avoided through timely communication of the investigative results to the operating division.</p>	<p>The operating division takes action based on the results of OIG investigation to suspend or terminate payments to the offending individual or entity.</p>	<p>\$29.9</p>
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**Appendix B**  
**Unimplemented Office of Inspector General Recommendations**  
**to Put Funds to Better Use**

This schedule represents potential annual savings or one-time recoveries which could be realized if Office of Inspector General (OIG) recommendations were enacted by the Congress and the administration through legislative or regulatory action, or policy determinations by management. (In many cases, these recommendations are beyond the direct authority of the departmental operating division.) It should be noted, however, that the Congress normally develops savings over a budget cycle which results in far greater dollar impact statements. Savings are based on preliminary OIG estimates and reflect economic assumptions which are subject to change. The magnitude of the savings may also increase or decrease as some of the proposals could have interactive effects if enacted together.

More detailed information may be found in OIG's *Red Book* which can be accessed on the Internet at <http://oig.hhs.gov>.

<b>OIG Recommendation</b>	<b>Status</b>	<b>Savings (millions)</b>
<b>Centers for Medicare and Medicaid Services</b>		
<p><b>Medicare Coverage of State and Local Government Employees:</b>            The CMS should require Medicare coverage and hospital insurance contributions for all state and local employees, including those hired prior to April 1, 1986. If this proposal is not enacted, CMS should seek legislation making Medicare the secondary payer for retirees of exempt state and local government agencies (CIN: A-09-88-00072)</p>	<p>In responding to OIG's report, CMS agreed with the recommendation to mandate Medicare coverage for all state and local government employees. However, this proposal was not included in the President's FY 2003 budget. The CMS did not agree with the recommendation to make Medicare the secondary payer.</p>	\$1,559
<p><b>Excessive Medicare Payments for Prescription Drugs:</b>            The CMS should examine its Medicare drug reimbursement methodologies.            (OEI-03-00-00310; OEI-03-97-00292;            OEI-03-97-00293; OEI-03-97-00390;            OEI-03-95-00420; OEI-03-94-00390)</p>	<p>The CMS concurred; they have attempted administrative remedies to lower payments for some drugs using "inherent reasonableness," but Congress suspended use of this authority pending issuance of federal rule-making. In addition, legislation passed on December 21, 2002, requires GAO to complete a comprehensive drug-pricing study before CMS can begin using average wholesale pricing as a way to lower prices for certain drugs.</p>	\$1,600
<p><b>Clinical Laboratory Tests:</b>            The CMS should develop a methodology and legislative proposal to pay for tests ordered as custom panels at substantially less than the full price for individual tests, and study reinstating the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization.            (CINs: A-09-89-00031; A-09-93-00056)</p>	<p>The CMS initially agreed with the first recommendation but not the second. The BBA required the Secretary to contract with the Institute of Medicine for a study of Part B laboratory test payments. The study was completed in December 2000, and the report was provided to CMS.</p>	\$1,130*

\*This savings estimate would result from the copayment; the savings estimate for panels has yet to be determined.

<p><b>Hospital Capital Costs:</b>          The CMS should determine the extent that capital reductions are needed to fully account for hospitals' excess bed capacity and report the percentage to the Congress.          (CINs: A-09-91-00070; A-14-93-00380)</p>	<p>The CMS did not agree with the recommendation. Although the BBA of 1997 reduced capital payments, it did not include the effect of excess bed capacity and other elements included in the base-year historical costs. The President's FY 2001 budget would have reduced capital payments and saved \$630 million in FY 2001 through FY 2005.</p>	<p>\$820</p>
<p><b>Ensure Appropriateness of Medicare Payments for Mental Health Services:</b>          The CMS should ensure mental health services are medically necessary, reasonable, accurately billed, and ordered by an authorized practitioner by using a comprehensive program of targeted medical reviews, provider education, improved documentation requirements, and increased surveillance of mental health services.          (OEI-02-99-00140, OEI-03-99-00130 CINs: A-04-98-02145, A-01-99-00507, A-01-99-00530;)</p>	<p>The CMS concurred and has initiated some efforts, particularly regarding community mental health centers.</p>	<p>\$685</p>
<p><b>Payment Policy for Medicare Bad Debts:</b>          The OIG presented four options for CMS to consider, including the elimination of a separate payment for bad debts, the offset of Medicare bad debts against beneficiary Social Security payments, the limitation of bad debt payments to prospective payment system hospitals that are profitable, and the inclusion of a bad debt factor in the diagnosis-related group (DRG) rates. The CMS should seek legislative authority to further modify bad debt policies. (CIN: A-14-90-00339)</p>	<p>In responding to OIG's report, CMS agreed with the recommendation to include a bad debt factor in the DRG rates. The BBA of 1997 provided for some reduction of bad debt payments to providers. The Benefits Improvement and Protection Act (BIPA) of 2000 subsequently increased bad debt reimbursement. However, additional legislative changes are needed to implement the modifications that OIG recommended.</p>	<p>\$340</p>
<p><b>Review Cost Effectiveness of "Pay and Chase" Methods for Medicaid Pharmacy Third-Party Liability Recoveries:</b>          The CMS should determine whether states cost-avoidance waivers for pharmacy claims are meeting the cost-effectiveness criterion. The CMS can ascertain cost effectiveness by requiring states to track dollars that they pay and chase and the amounts that they recover. The CMS should also review states' policies to determine if they are paying and chasing pharmacy claims without waivers. (OEI-03-00-00030)</p>	<p>The CMS agreed that states' cost-avoidance waivers should be reexamined and is directing the regional offices to reevaluate the waivers and determine if states are paying and chasing claims without waivers. In addition, CMS is working with states that currently cost-avoid pharmacy claims and is developing guidance to assist them in implementing cost-avoidance.</p>	<p>\$185</p>
<p><b>Graduate Medical Education:</b>          The CMS should revise the regulations to remove from a hospital's allowable graduate medical education (GME) base-year costs any cost center with little or no Medicare utilization and submit a <i>continued</i>—</p>	<p>The CMS did not concur with the recommendations. Although the BBA of 1997 and the BBRA of 1999 contained provisions to slow the growth in Medicare spending on GME, OIG believes that</p>	<p>\$157.3</p>

<p><b>Graduate Medical Education (continued—)</b> legislative proposal to compute Medicare's percentage of participation under the former, more comprehensive system. (CIN: A-06-92-00020)</p>	<p>its recommendations should be implemented and that further savings can be achieved.</p>	
<p><b>Review Medicaid Reimbursement Methodology for HIV/AIDS Drugs:</b> The CMS should review the current reimbursement methodology and work with states to more accurately estimate pharmacy acquisition costs for 16 HIV/AIDS drugs examined and initiate a review of Medicaid rebates for them. (OEI-05-99-00611)</p>	<p>The CMS no longer believes the recommended change is necessary and believes that reimbursement changes will occur through revised AWP, based on the President's budget proposal for a legislative change that would base the Medicaid drug rebate on the difference between AWP and the best price for a drug.</p>	<p>\$140</p>
<p><b>Paperless Claims:</b> The CMS should lead a target outreach to encourage voluntary conversion to paperless Medicare claim filing by physicians who submit claims on paper and who have a moderate to high level of interest in making the switch. This effort should be coordinated with efforts to promote further use of electronic data interchange by providers under the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996. The CMS should begin to plan now for the policy changes that will be necessary to achieve an almost completely paperless environment for processing Medicare claims. These policy changes can include targeting a date when all physicians will be mandated to submit paperless claims, targeting a date when paperless claim submission will become a condition for Medicare participation, or continuing to accept paper claims, but imposing a filing fee to cover the incremental cost of doing so. (CIN: A-05-94-00039; OEI-01-94-00230)</p>	<p>The CMS concurred with OIG's recommendations. The administration's proposal for both FY 2002 and 2003 would assess a \$1.50 fee on most, but not necessarily all, paper claims. Also, under the CMS Claims Processing User Fee Act of 2001, significant outreach to providers will be conducted.</p>	<p>\$126</p>
<p><b>Medicaid Drug Rebate Program:</b> The best price calculation in the Medicaid drug rebate program should be indexed to the consumer price index-urban. (CIN: A-06-94-00039)</p>	<p>Disagreeing with the recommendation, CMS believes that savings will be achieved through the President's budget proposal to enact a legislative change that would base the drug rebate on the difference between the AWP and the best price for a drug.</p>	<p>\$123</p>
<p><b>Identify Medical Equipment/Supply Claims Lacking Valid, Active UPINs:</b> The CMS should create edits to identify medical equipment and supply claims that do not have a valid and active unique physician identification number (UPIN) listed for the ordering physician. (OEI-03-01-00110)</p>	<p>The CMS concurred. The agency planned to implement an edit to reject claims listing a deceased physician's UPIN beginning in April 2002 and later expand this to include all inactive and invalid UPINs.</p>	<p>\$91</p>

Appendix B

<p><b>Expansion of the DRG Payment Window:</b> The CMS should propose legislation to expand the DRG payment window to at least 7 days immediately prior to the day of admission. (CIN: A-01-92-00521)</p>	<p>The CMS did not concur with the recommendation, and no legislative proposal was included in the President's FY 2001 budget.</p>	<p>\$83.5</p>
<p><b>Inpatient Psychiatric Care Limits:</b> The CMS should develop new limits to deal with the high cost and changing utilization patterns of inpatient psychiatric services and apply a 60-day annual and a 190-day lifetime limit to all psychiatric care regardless of the place of service. (CIN: A-06-86-62045)</p>	<p>The CMS agreed with OIG's findings but stated that further analysis would be required before any legislative changes could be supported.</p>	<p>\$47.6</p>
<p><b>Nonemergency Advanced Life Support Ambulance Services:</b> The CMS should modify its Medicare policy to allow payment for nonemergency advanced life support ambulance service only when that level of service is medically necessary, instruct carriers to institute controls to ensure that payment is based on the medical need of the beneficiary, and closely monitor carrier compliance. (CINs: A-01-91-00513; A-01-94-00528)</p>	<p>The BBA of 1997 required that CMS link payments to services provided and that the definitions of basic life support and advanced life support ambulance services be subject to negotiated rulemaking. The Negotiated Rulemaking Committee Statement on the Medicare Ambulance Services Fee Schedule was signed in February 2000. The CMS published the final rule in the <i>Federal Register</i> in February 2002.</p>	<p>\$47</p>
<p><b>Medicare Orthotics:</b> The CMS should take action to improve Medicare billing for orthotic devices. The CMS should also require standards for suppliers of custom-molded and custom-fabricated orthotic devices. (OEI-02-95-00380, OEI-02-99-00120, OEI-02-99-00121)</p>	<p>Although CMS concurred with OIG's original recommendations, problems continue.</p>	<p>\$43</p>
<p><b>Reimbursement for Hospital Beds:</b> The CMS should take immediate steps to reduce Medicare payments for hospital beds used in the home. This should include the elimination of the higher reimbursement rate currently paid during the first 3 months of rental. (CIN: A-06-91-00080; OEI-07-96-00221; OEI-07-96-00222)</p>	<p>The CMS concurred and is considering options to determine the best approach to achieve a fair price for hospital beds. The agency is examining payment allowances and methodologies at other payers and is reviewing data to determine if Medicare payments are excessive. However, the BBRA of 1999 imposed a moratorium on the application of CMS' "inherent reasonableness" authority. Thus, while the moratorium is in place, CMS may not act on a determination that costs are excessive. The BIPA of 2000 increased DME payments by 3.7 percent for 2001.</p>	<p>\$40</p>

<p><b>End Stage Renal Disease Payment Rates:</b> The CMS should reduce the payment rates for outpatient dialysis treatments to reflect current efficiencies and economies in the marketplace. (CIN: A-14-90-00215)</p>	<p>The CMS agreed that the composite payment rates should reflect the costs of outpatient dialysis treatment in efficiently operated facilities, and the BBA of 1997 required the Secretary to audit the cost reports of each dialysis provider at least once every 3 years. The BBRA of 1999 increased each composite rate payment for dialysis services furnished during 2000 by 1.2 percent above the payment for services provided on December 31, 1999. The BIPA of 2000 increased the rate for services provided in 2001 by 2.4 percent and required the Secretary to develop a composite rate that includes, to the extent feasible, payment for clinical diagnostic laboratory tests and drugs that are routinely used in dialysis treatments but are currently separately billable.</p>	<p>\$22*</p>
<p><b>Medicaid Reimbursement for Clinical Laboratory Services:</b> State agencies should install edits to detect and prevent payments for clinical laboratory services that exceed the Medicare limits and billings that contain duplicate tests, recover overpayments, and make adjustments for the federal share of the amounts recovered. (CINs: A-01-95-00005; A-05-95-00035; A-01-96-00001; A-06-95-00078; A-06-95-00031; A-04-95-01108; A-04-95-01109; A-07-95-01139; A-07-95-01147; A-04-95-01113; A-07-95-01138; A-09-95-00072; A-05-96-00019; A-10-95-00002; A-01-95-00006; A-02-95-01009; A-03-96-00200; A-03-96-00202; A-03-96-00203; A-05-95-00062; A-06-96-00002; A-06-95-00100; A-04-98-01185; A-03-00-00204; A-01-01-00003)</p>	<p>The CMS wrote to all state Medicaid directors in January 1997, alerting them to OIG's review, encouraging them to use Medicare's bundling policies, and urging them to install appropriate payment edits in their claim processing systems. The OIG is conducting several follow-up reviews in this area.</p>	<p>\$17.8</p>
<p><b>Reclassify Respiratory Assist Devices with a Back-Up Rate:</b> The CMS should reclassify bi-level respiratory assist devices with a back-up rate from the "frequent and substantial servicing" category to the "capped rental" category under the durable medical device benefit. (OEI-07-99-00440)</p>	<p>The CMS concurred.</p>	<p>\$11.5</p>

*\*This estimate represents annual program savings of \$22 million for each dollar reduction in the composite rate, given the population of ESRD beneficiaries at the time of OIG's review.*

Appendix B

<p><b>Medicare Claims for Railroad Retirement Beneficiaries:</b> The CMS should discontinue use of a separate carrier to process Medicare claims for railroad retirement beneficiaries. (CIN: A-14-90-02528)</p>	<p>The FY 2002 and 2003 budgets did not include this type of legislative proposal.</p>	<p>\$9.1</p>
<p><b>Indirect Medical Education:</b> The CMS should reduce the indirect medical education (IME) adjustment factor to the level supported by CMS' empirical data and initiate further studies to determine whether different adjustment factors are warranted for different types of teaching hospitals. (CIN: A-07-88-00111)</p>	<p>The CMS agreed with the recommendation, and the BBA of 1997, as amended by the BBRA of 1999, reduced the IME adjustment to 5.5 percent in 2002 and thereafter. The OIG believes the factor should be further reduced to eliminate any overlap with the disproportionate share adjustment.</p>	<p>TBD*</p>
<p><b>Medicare Secondary Payer—End Stage Renal Disease Time Limit:</b> The CMS should extend the Medicare secondary payer (MSP) provisions to include end stage renal disease (ESRD) beneficiaries without a time limitation. (CIN: A-10-86-62016)</p>	<p>The CMS was concerned that an indefinite MSP provision might encourage insurers to drop uneconomical services, namely facility dialysis and transplantation. The OIG continues to advocate that when Medicare eligibility is due solely to ESRD, the group health plan should remain primary until the beneficiary becomes entitled to Medicare for old age or disability. At that point, Medicare would become the primary payer.</p>	<p>TBD</p>
<p><b>Home Health Agencies:</b> The CMS should revise Medicare regulations to require the physician to examine the patient before ordering home health services. (OEI-04-93-00262; OEI-04-93-0026; OEI-12-94-00180; OEI-02-94-00170; CINs: A-04-95-01103; A-04-95-01104; A-04-94-02087; A-04-94-02078; A-04-96-02121; A-04-97-01169; A-04-97-01166; A-04-97-01170; A-04-99-01195)</p>	<p>Although the BBA of 1997 included provisions to restructure home health benefits, CMS still needs to revise Medicare regulations to require that physicians examine Medicare patients before ordering home health services. Subsequent to the BBA, OIG's four-state review found that unallowable services continued to be provided because of inadequate physician involvement. While agreeing in principle, CMS said it would continue to examine both coverage rules and conditions of participation to develop the discipline necessary for ensuring proper certification. Also, CMS established additional payments for physician care plan oversight and undertook efforts to educate physicians and beneficiaries.</p>	<p>TBD</p>
<p><b>Connection Between the Calculation of Medicaid Drug Rebates and Drug Reimbursement:</b> The CMS should seek legislation that would require participating manufacturers to pay Medicaid drug <i>continued—</i></p>	<p>The CMS agreed to pursue a change in the rebate program similar to that recommended. The President's FY 2003 budget proposes a legislative change that would base the drug rebate on the difference</p>	<p>TBD</p>

\*To be determined.

<p><b>Connection Between the Calculation of Medicaid Drug Rebates and Drug Reimbursement (continued—)</b>  rebates based on average wholesale price (AWP) or study other viable alternatives to the current program of using average manufacturer price (AMP) to calculate the rebates. This legislation would have resulted in about \$1.15 billion in additional rebates for 100 brand-name drugs with the highest total Medicaid reimbursements in calendar years 1994-96. (CIN: A-06-97-00052)</p>	<p>between the AWP and the best price for a drug.</p>	
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*Various Operating Divisions*

<p><b>Medicare Rates for Indian Health Service Contracted Health Services:</b>  The Indian Health Service (IHS) should revise its legislative proposal to incorporate OIG's updated savings figures and should identify elements to be included in the implementing regulations. Also, IHS should continue to pursue the most favorable rates at hospitals that have previously offered less than Medicare rates and should strategically identify and pursue other opportunities where lower rates may be negotiated. (CIN: A-15-97-50001)</p>	<p>The IHS concurred with OIG's recommendations. However, the proposal was not included in the President's FY 2003 budget.</p>	<p>\$8.2</p>
<p><b>Recharge Center Costs:</b>  The Assistant Secretary for Administration and Management should propose changes to OMB Circular A-21 to improve guidance on the financial management of recharge centers. The revision should include criteria for establishing, monitoring, and adjusting billing rates to eliminate accumulated surpluses and deficits; preventing the use of recharge funds for unrelated purposes and excluding unallowable costs from the calculation of recharge rates; ensuring that federal projects are billed equitably; and excluding recharge costs from the recalculation of facilities and administrative cost rates. (CIN: A-09-96-04003)</p>	<p>The Deputy Assistant Secretary for Grants and Acquisition Management concurred. In addition, the Council on Government Relations generally agreed and stated that the proposed criteria should be included in the Compliance Supplement to OMB Circular A-133, which provides guidance to independent auditors in conducting compliance audits of educational institutions. This suggestion was forwarded to OMB for consideration.</p>	<p>\$1.9</p>



**Appendix C**  
**Unimplemented Office of Inspector General Program**  
**and Management Improvement Recommendations**

This schedule represents Office of Inspector General (OIG) findings and recommendations which, if implemented, would result in substantial benefits. The benefits relate primarily to effectiveness rather than cost-efficiency.

More detailed information may be found in OIG's *Orange Book* which can be accessed on the Internet at <http://oig.hhs.gov>.

**OIG Recommendation**

**Status**

**Centers for Medicare and Medicaid Services**

<p><b>Accountability Over Billing and Collection of Medicaid Drug Rebates:</b>  The CMS should ensure that states implement accounting and internal control systems in accordance with applicable federal regulations for the Medicaid drug rebate program. Such systems must provide for accurate, current, and complete disclosure of drug rebate transactions and provide CMS with the financial information it needs to effectively monitor and manage the Medicaid drug rebate program.  (CIN: A-06-92-00029)</p>	<p>The CMS concurred with the recommendation. States will now be required to maintain detailed supporting records of all rebate amounts invoiced to drug companies using a formal accounts receivable system. The CMS issued a notice of proposed rulemaking in FY 1996.</p>
<p><b>Fairly Presenting the Medicare Accounts Receivable Balance:</b>  The CMS should require Medicare contractors to implement or improve internal controls and systems to ensure that reported accounts receivable are valid and documented.  (CINs: A-17-95-00096; A-17-97-00097;  A-17-98-00098; A-17-00-00500; A-17-00-02001)</p>	<p>The CMS hired consultants to assist in validating the FY 1999 accounts receivable activity and balance, as well as the activity for the first 6 months of FY 2000. The President's FY 2001 budget included funding to establish financial management controls at the contractors and to hire contractor staff to implement the controls. For the long term, CMS is developing an integrated general ledger system as the cornerstone of its financial management controls.</p>
<p><b>Safeguards Over Medicaid Managed Care Programs:</b>  The CMS should consider safeguards available to reduce the risk of insolvency and to ensure consistent and uniform state oversight.  (CIN: A-03-93-00200)</p>	<p>Although CMS initially concurred with some specific recommendations, the agency believes that section 4706 of the BBA of 1997 sets forth congressional expectations on this issue in specifically requiring managed care organizations to meet the solvency standards established by the state for private health maintenance organizations.</p>
<p><b>Guidance to Drug Manufacturers to Better Implement the Medicaid Drug Rebate Program:</b>  The CMS should survey manufacturers to identify the various calculation methods used to determine average manufacturer price (AMP). The CMS should also develop a more specific policy for calculating AMP  <i>continued—</i></p>	<p>The CMS did not concur, stating that the drug law and the rebate agreements already established a methodology for computing AMP. The OIG disagreed because the rebate law and agreement defined AMP but did not provide specific written methodology for computing AMP.</p>

Appendix C

<p><b>Guidance to Drug Manufacturers to Better Implement the Medicaid Drug Rebate Program (continued—)</b>          which would protect the interests of the government and which would be equitable to the manufacturers. (CIN: A-06-91-00092)</p>	<p>.</p>
<p><b>Physician Office Surgery:</b>          The peer review organizations (PROs) should extend their review to surgery performed in physicians’ offices. (OEI-07-91-00680)</p>	<p>The CMS has issued policy guidance and manual instructions to explicitly state that PROs have the responsibility to review all care in physician offices when a beneficiary complains.</p>
<p><b>Ensure Accuracy of Carrier Payment Data:</b>          The CMS should conduct a review of carriers’ claims processing data to examine the scheduled date of payment entered on claims sent to the Common Working File (CWF). If there is no correlation between the claims payment date variable and the actual date of payment, CMS should define what data should be entered into this field and how it should be calculated, and/or revise the current variable definition to clarify for National Claims History data users that the schedule date of payment is not an accurate reflection of the actual claim payment date. The CMS should also review the carriers’ claims processing data to determine the accuracy of the information contained in the CROWD system. (OEI-03-00-00350)</p>	<p>The CMS stated that a review is under way to compare data contained in the National Claims History File with data at the carrier level. In addition, CMS has approved two new edits which will enforce the payment floor standards on claims sent to the CWF.</p>
<p><b>Prevent Duplicate Payments for the Same Service by Multiple Carriers:</b>          The CMS should revise CWF edits to detect and deny duplicate billings to individual carriers or to more than one carrier, or increase post-payment reviews if such edits are determined not to be cost effective. (OEI-03-00-00090, OEI-03-00-00091)</p>	<p>The CMS concurred with OIG’s recommendations and will re-examine existing criteria regarding duplicate editing in the CWF system to determine the cost effectiveness of including the carrier number in the match criteria. The CMS entered a contract to study duplicate billing</p>
<p><b>Prevent Inappropriate Payments for Blood Glucose Test Strips:</b>          The CMS should alert suppliers of the importance of properly completed documentation to support their claims for test strips; require suppliers to indicate actual and accurate “start” and “end” dates on claim forms; promote supplier concurrence and cooperation with OIG’s recently issued compliance guidelines; and advise beneficiaries to report any instances of fraudulent or abusive practices involving their home blood glucose monitors, test strips, or related supplies to their DMERCs. (OEI-03-98-00230)</p>	<p>The CMS concurred with the recommendations and noted a number of initiatives that have reduced the incidence of improper payments in recent years.</p>

<p><b>Educate Beneficiaries on Reducing Financial Liability for DME:</b> The CMS should educate beneficiaries on ways to reduce financial liability for medical equipment and supplies and re-evaluate Medicare fee schedules for ostomy supplies. (OEI-07-99-00510)</p>	<p>The CMS concurred with OIG’s recommendations and has undertaken a number of efforts to increase beneficiary education and awareness about the consequences of assigned and non-assigned claims.</p>
<p><b>Change DME Payment Category for Respiratory Assist Devices:</b> The CMS should move the bi-level respiratory assist device with a backup rate from the frequent and substantial servicing payment category to the capped rental payment category. (OEI-07-99-00440)</p>	<p>The CMS concurred with OIG’s recommendation, stating that it plans to move the bi-level respiratory assist device with a back-up rate from the “frequent and substantial servicing” payment category to the capped rental payment category. The CMS believes this change is needed to reflect the requirements of Section 1834 (a) (3) of the Social Security Act</p>
<p><b>Improve Resident Assessment Instruments:</b> The CMS should more clearly define minimum data set (MDS) elements and work with states to train nursing home staff. The OIG also recommend that CMS establish an audit trail to validate the 108 MDS elements that affect facility reimbursement by Medicare. (OEI-02-99-00040, OEI-02-99-0041)</p>	<p>The CMS generally concurred with OIG’s recommendations for improved data definitions and training, but did not concur with the recommendation to establish an audit trail.</p>
<p><b>Improve Assessments of Mental Illness:</b> The OIG recommended that CMS work with states to improve the assessment of persons with serious mental illness and use survey and certification to monitor compliance. The OIG also recommended that CMS define specialized services that are to be provided by the state to nursing home residents with mental illness. (OEI-05-99-00700)</p>	<p>The CMS concurred with most of OIG’s recommendations and has made revisions to its training curriculum for nursing home surveyors.</p>
<p><b>Identify Nursing Home Residents with Serious Mental Illness:</b> The CMS should improve the quality and usefulness of these data sources by requiring the use of a unique provider number across systems, requiring reporting of resident data by age and diagnosis, and encouraging states to use these data in demonstrating their progress in placing disabled persons in the most integrated settings. The OIG also recommends training to improve data collection and accurate coding. (OEI-05-99-00701)</p>	<p>Except for reporting MDS records by primary, secondary, and tertiary diagnoses, CMS concurred with most of OIG’s recommendations. The CMS does not feel that adding space to the MDS to record diagnoses would solve the problem.</p>
<p><b>Eliminate Inappropriate Payments for Mental Health Services:</b> The CMS should promote provider awareness of documentation and medical necessity requirements, develop a comprehensive list of psychological testing tools that can be correctly billed, target problematic services for pre-payment edits or post-payment <i>continued—</i></p>	<p>The CMS generally concurred with the recommendations and plans to explore a variety of educational efforts and will refer the reports to the carrier clinical workgroup on psychiatric services. Carriers will conduct data analysis of psychological testing and psychotherapy claims and will conduct medical review, if indicated.</p>

Appendix C

<p><b>Eliminate Inappropriate Payments for Mental Health Services (continued—)</b>          medical review, and encourage carriers to take advantage of the MDS, especially for its assessment of patient cognitive level.          (OEI-03-99-00130, OEI-02-99-00140)</p>	
<p><b>Lower Medicaid Expenditures on HIV/AIDS Drugs:</b>          For the 16 HIV/AIDS drugs examined in this study, OIG recommend that CMS review the current reimbursement methodology and work with states to find a method that more accurately estimates pharmacy acquisition cost and review Medicaid rebates for the drugs examined. (OEI-05-99-00611)</p>	<p>The CMS agreed with the overall intent of OIG’s recommendations, but expressed reservations with many of the specific suggestions offered for achieving them. Primarily, CMS felt that it does not have the statutory authority to make the suggested changes.</p>
<p><b>Increase Organ Donation:</b>          The CMS should revise the Medicare conditions for coverage for Organ Procurement Organizations (OPOs) to make them more accountable for implementing the new donation rule and require OPOs to provide hospital-specific data on referrals and on organ recovery. The HRSA should require that OPOs submit hospital-specific data on referrals and on organ recovery and support demonstration projects on how to effectively train and make use of designated requestors. (OEI-01-99-00020)</p>	<p>The CMS concurred with the recommendations and indicated it will explore ways in which additional data can be used to assess OPO effectiveness and hospital compliance with the donation rule. The HRSA also concurred with the recommendations.</p>

**Various Public Health Agencies**

<p><b>Improve Oversight of Tissue Banking:</b>          The FDA should expedite publication of its regulatory agenda requiring registration of tissue banks, enhanced donor suitability screening and testing, and the use of good tissue practices. The FDA should set a realistic, yet aggressive, date by which it would complete an initial inspection of all tissue banks. The FDA should determine the appropriate minimum cycle for tissue bank inspections, and work with states and professional associations to determine in what areas oversight activities could be coordinated.          (OEI-01-00-00441)</p>	<p>The Deputy Secretary concurred that FDA should expedite its planned rulemaking activities related to tissues, specifically the final rule to require registration of tissue banks. The department also found “considerable merit” in OIG’s recommendation for an intensified inspection program directed towards entities that procure, process, and store human tissues. In Congressional testimony, FDA said that all three of the proposed rules have been published, and one rule (Establishment Registering and Listing) was finalized. The FDA also worked to inspect all 36 identified, uninspected tissue banks.</p>
<p><b>Improve Effectiveness of the FDA’s Adverse Event Reporting System for Dietary Supplements:</b>          The OIG recommends that FDA 1) facilitate greater detection of adverse events by requiring dietary supplement manufacturers to report serious events to FDA for some products; 2) obtain more information on adverse event reports by requiring manufacturers to register themselves and their products with FDA; 3) notify manufacturers when FDA receives a serious  <i>continued—</i></p>	<p>The FDA agreed with the majority of OIG’s recommendations. The Center for Food Safety and Applied Nutrition (CFSAN) indicated that it has embarked on significant efforts to enhance its adverse event reporting system through development of a new system called the CFSAN Adverse Event Reporting System.</p>

<p><b>Improve Effectiveness of the FDA’s Adverse Event Reporting System for Dietary Supplements (continued—)</b> adverse event report and develop a new computer database to track and analyze adverse event reports; 4) expedite the development and implementation of good manufacturing practices for dietary supplement manufacturers; and 5) disclose more useful information to the public about dietary supplement adverse events. (OEI-01-00-00180)</p>	
<p><b>Improve Protection for Research Subjects in Foreign Clinical Trials:</b> The FDA should examine ways to obtain more information about the performance of non-US Institutional Review Boards (IRBs) and help those inexperienced IRBs build their capacities; encourage all non-US investigators participating in research to sign attestations upholding human subject protections; and develop a database to track the growth and location of foreign research. The OHRP should exert leadership in developing strategies to ensure adequate human subject protections for non-US clinical trials funded by the Federal Government and those that contribute data to new drug applications. (OEI-01-00-00190)</p>	<p>The FDA supported OIG’s recommendations, but noted that in most cases it did not have the resources to implement the recommendations. The OHRP concurs with the recommendations and emphasized that its new Office of International Activities “will serve as a focal point and coordinating center” for the department’s efforts to improve human subject protection.</p>
<p><b>Improve Managed Care Organizations Reporting to the National Practitioner Data Bank:</b> The Agency for Health Care Research and Quality should devote attention to the kind of educational and remedial efforts that could be directed to practitioners who have been experiencing performance problems. The HRSA should conduct an outreach program to inform managed care organizations of their reporting responsibilities, and CMS should examine its practitioner monitoring systems. (OEI-01-99-00690)</p>	<p>The HRSA awarded a contract to Price Waterhouse Coopers to look at the feasibility study for assessing compliance with the NPDB reporting requirements. The feasibility study addresses both hospital and managed care organizations reporting.</p>
<p><i>Administration for Children and Families</i></p>	
<p><b>Improve the Establishment of Child Support Orders for Low-Income Non-Custodial Parents:</b> The ACF’s Office of Child Support Enforcement should work with states to emphasize parental responsibility and improve the ability of low-income non-custodial parents to meet their obligations. The ACF should facilitate and support state experiments to test the payment effects of using various periods of retroactivity in determining the amount of support owed; facilitate and support state experiences to test negotiating child support debt owed to the states in exchange for improved payment compliance. (OEI-05-99-00391)</p>	<p>The ACF is helping ten states test approaches to serving young, never-married fathers who may have obstacles to employment and who do not have a child support order. The ACF has granted a contract to determine how computerized income data can be used by local child support offices to independently verify the income of non-custodial parents and be used in the establishment or modification of child support orders where income documentation or verification is lacking or incomplete.</p>

**General Oversight**

**Cost Principles for Federally Sponsored Research Activities:**

The department should modernize and strengthen cost principles applicable to hospitals by either revising existing guidelines to conform with Office of Management and Budget (OMB) Circular A-21 or working with OMB to extend Circular A-21 coverage to all hospitals. (CIN: A-01-92-01528)

Hospital cost principles have been updated in a draft regulation which was expected to be issued as a notice of proposed rulemaking by September 30, 2002.

**Appendix D**  
**Notes to Tables 1 and 2**

**Notes to Table 1**

<sup>1</sup>The opening balance was adjusted upward \$39 million.

<sup>2</sup>During the period, revisions to previously reported management decisions included:

CIN: A-07-94-00761 Health Care Service Corp-Charging Pension Costs: Results of this audit were superseded by a later audit, in the amount of \$325,512.

CIN: A-03-92-03316 Human Services Res., Inc. Contract #U70-MHU000004: Based on additional documentation received, the costs are allowable. The amended amount of Cost Question is \$318,025.

CIN: A-05-97-47032 Bad River Band of Lake Superior Tribe of Chippewa. The contracting officer has stated that the \$172, 076 was used for acceptable allowable expenses and need not be returned.

Not detailed are revisions to previously disallowed management decisions totaling \$65,557.

<sup>3</sup>Included are management decisions to disallow \$19,662,000 that was identified in nonfederal audit reports.

<sup>4</sup>A.

Due to administrative delays, many of which are beyond management control, resolution of the following audits was not completed within 6 months of issuance; however, based upon discussions with management, resolution is expected before the end of the next semiannual reporting period:

CIN: A-04-00-02171 REV. AL MEDICAID INTERGOVERNMENTAL TRANSFERS - HOSP. ENHANC, MAY 2001, \$236,983,528

CIN: A-06-00-00041 INCORRECTLY REPORTED PPS TRANSFERS - CMS/OIG PROJECT, NOVEMBER 2001, \$163,900,000

CIN: A-06-00-00056 MEDICAID DRUGS - REVIEW OF REPACKAGED DRUGS EX FROM, MARCH 2001, \$108,000,000

CIN: A-04-00-01220 IMPL. MEDICARE'S POSTACUTE CARE TRANSFER POLICY, OCTOBER 2001, \$52,311,082

CIN: A-04-98-00123 REVIEW FOSTER CARE PMTS - CHILD CARE IN NC, APRIL 2001, \$48,183,445

CIN: A-01-00-00538 NATIONAL IDENTIFICATION OF SNF CONSOLIDATED BILLING, JUNE 2001, \$47,633,686

CIN: A-01-00-00509 M/C PART B PMTS FOR DME PROVIDED TO SNF PATIENTS, JULY 2001, \$35,000,000

CIN: A-04-00-65030 STATE OF SOUTH CAROLINA, JULY 2000, \$31,755,510

CIN: A-07-99-01279 OP PSYCH, JANUARY 2001, \$18,515,190

CIN: A-06-00-00051 AUDIT OF MEDICARE REHAB AGENCY COSTS IN TX, RHS, I, JUNE 2001, \$18,394,465

CIN: A-05-01-00052 DME REVIEW IN INDIANA, OCTOBER 2001, \$16,377,560 (Related recommendation of \$4,400,000 outstanding on Table 2)

CIN: A-06-01-00035 COLLECTION OF AFDC OVERPAYMENTS, JANUARY 2002, \$13,800,000

CIN: A-01-01-02501 REVIEW OF CT RETROACTIVE FOSTER CARE PAYMENTS CLAIMED UNDER TITLE IV-E, SEPTEMBER 2002, \$13,238,313

CIN: A-01-01-02502 REVIEW OF UNCOLLECTED AFDC OVERPAYMENTS, AUGUST 2001, \$12,400,000

CIN: A-07-01-02616 REVIEW OF MUTUAL'S OVERSIGHT OF PIP, AUGUST 2001, \$11,336,867

CIN: A-01-01-00513 MEDICARE PT B PMT FOR DME I/P PRTL MNTH STAYS SNF, OCTOBER 2001, \$10,500,000

*Appendix D*

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CIN: A-05-00-00045 OIG PARTNERSHIP: STATE AUDITOR REPORT ON MEDICAID, MAY 2000, \$8,500,000

CIN: A-09-97-44262 STATE OF CALIFORNIA, APRIL 1997, \$7,300,000

CIN: A-03-91-00552 INDEPENDENT LIVING PROGRAM - NATIONAL, MARCH 1993, \$6,529,545 (Related recommendation of \$10,161,742 outstanding on Table 2)

CIN: A-02-99-02001 NYS REV OF RETROACTIVE KINSHIP CLAIMS, SEPTEMBER 2000, \$5,833,676

CIN: A-03-99-00052 ALLEGHENY/CHESAPEAKE ORF, SEPTEMBER 2001, \$5,540,344 (Related recommendation of \$467,646 outstanding on Table 2)

CIN: A-04-00-02161 MEDICAID SCHOOL-BASED SERVICES IN NORTH CAROLINA, NOVEMBER 2001, \$5,344,160

CIN: A-07-99-02537 BLUE CROSS & BLUE SHIELD OF MASSACHUSETTS, NOVEMBER 1999, \$5,270,461

CIN: A-01-00-00506 DIAGNOSIS-RELATED GROUP PAYMENT WINDOW, JULY 2001, \$5,042,207

CIN: A-01-97-00516 ADMIN. COSTS - PART A&B, RAILROAD RETIRE BOARD, JUNE 1999, \$4,939,184

CIN: A-05-01-00023 ADMINISTRATIVE COSTS REVIEW - ADMINASTAR FEDERAL, JANUARY 2002, \$4,694,863

CIN: A-02-00-01047 DEMO BSWNY-FINANCIAL, MARCH 2002, \$4,505,051

CIN: A-07-96-02001 MEDICARE PART B ADMIN COSTS AT BC/BS COLORADO, DECEMBER 1996, \$4,483,104

CIN: A-07-98-01263 DENVER CMHC, MAY 2000, \$4,447,607

CIN: A-07-00-00108 RURAL HEALTH CENTER REVIEW, OCTOBER 2001, \$4,088,929

CIN: A-04-01-05002 AUDIT MEDICAID PAYMENTS FOR CLINICAL LABORATORIES, JANUARY 2002, \$3,522,639

CIN: A-07-00-00109 MEDICARE CONTRACT TERM. & SEG. CLOSING - GALIC, SEPTEMBER 2000, \$3,505,560

CIN: A-03-00-00002 TRIGON PT-A AND TERMINATION, SEPTEMBER 2001, \$3,464,705

CIN: A-02-95-01019 STAFF BUILDERS HOME OFFICE MEDICARE COST REV. ORT, AUGUST 1998, \$3,434,274

CIN: A-05-93-00054 IL-ASSOCIATED INSURANCE GROUP-CONTRACT AUDIT, OCTOBER 1993, \$3,355,560

CIN: A-07-99-01283 HMO - AFTER DEATH PAYMENTS, FEBRUARY 2000, \$3,250,000

CIN: A-07-99-01298 DATE OF DEATH-2, MAY 2001, \$3,200,000 (Related recommendation of \$700,000 outstanding on Table 2II)

CIN: A-03-94-00029 VERITUS INC - ADMIN COST, FEBRUARY 1998, \$3,140,363

CIN: A-05-98-00042 ADMINISTAR INS. CO. - ADMIN. COSTS AUDIT, SEPTEMBER 1999, \$3,111,728

CIN: A-06-99-00057 AUDIT OF MEDICARE REHAB AGENCY SRVCS IN TX, RHS, IN, JANUARY 2001, \$3,097,201

CIN: A-09-98-50183 STATE OF CALIFORNIA, MARCH 1998, \$3,000,000

CIN: A-07-01-00132 INDEPENDENCE BLUE CROSS - PENSION SEGMENT CLOSING AUDIT, FEBRUARY 2002, \$2,913,129

CIN: A-01-96-00508 MEDICARE ADMIN COSTS PARTS A&B AND RRB - TRAVELERS, MARCH 1996, \$2,803,260

CIN: A-05-97-00005 ADMINISTRATIVE COSTS CLAIMED UNDER MEDICARE A & B, FEBRUARY 1998, \$2,569,067

CIN: A-05-92-00026 ASSOCIATED INSURANCE CO. - MEDICARE ADMIN, FEBRUARY 1992, \$2,530,409

CIN: A-02-91-01006 BLUE SHIELD OF WESTERN NY MEDICARE ADM CTS PORTER, SEPTEMBER 1991, \$2,379,239

CIN: A-04-00-01209 OUTPATIENT PSYCHIATRIC SRVCS AT HOLLYWOOD PAV. HOSP, APRIL 2001, \$2,366,287

CIN: A-03-99-00038 EDGEWATER PSYC HOSPITAL, MARCH 2001, \$2,348,604 (Related recommendation of \$208,731 outstanding on Table 2)

CIN: A-04-97-01166 REV. HOME HEALTH SRVCS BY STAFF BUILDERS HOME HLTH, APRIL 1999, \$2,300,000

CIN: A-07-97-01247 DUPLICATE PAYMENTS - HMO/FFS, OCTOBER 1999, \$2,300,000

CIN: A-04-97-01170 REVIEW HOME HEALTH SRVCS BY MEDCARE HOME HLTH SRVCS, APRIL 1999, \$2,200,000

CIN: A-09-01-00056 PACIFICARE-CALIFORNIA JAN 1998 INSTITUTIONAL PMTS, SEPTEMBER 2001, \$2,158,577

CIN: A-07-01-68554 STATE OF NEBRASKA, JUNE 2001, \$2,113,388

CIN: A-04-00-02162 REVIEW TREATMENT OF QUALIFIED DISCHRG @ FCSO, FEBRUARY 2001, \$2,042,060

CIN: A-02-00-02502 UNIVERSITY OF MEDICINE & DENTISTRY CONTRACT AUDIT, APRIL 2001, \$2,002,011

CIN: A-05-00-00034 PROVENA ST. JOSEPH HOSPITAL-O/P PSYCH SERVICES, NOVEMBER 2000, \$1,978,583

CIN: A-04-97-01169 REVIEW HOME HLTH SRVCS BY MEDTECH HOME HLTH SRVCS, APRIL 1999, \$1,900,000

CIN: A-06-96-00009 NEW MEXICO BCBS ADMIN COST - CONTRACTED, NOVEMBER 1997, \$1,879,366

CIN: A-05-97-00014 GROUP HEALTH PLAN INC.(HEALTHPARTNERS) INST. BENES, JUNE 1998, \$1,808,308

CIN: A-03-00-00007 REVIEW OF 1-DAY DISCHARGES - PA., APRIL 2001, \$1,649,411 (Related recommendation of \$6,300,000 outstanding on Table 2)

CIN: A-04-97-02143 REVIEW THERAPY SRVCS IN LIFE CARE SNF'S IN TN, DECEMBER 1999, \$1,638,025

CIN: A-02-97-01039 MEDASSIST - ORT ORTHOTICS PROVIDER TARGET, NOVEMBER 1999, \$1,616,222

CIN: A-04-99-01196 OIG-HCFA JOINT REVIEW OF JMV MEDICAL CORP., DECEMBER 2000, \$1,600,417

CIN: A-03-00-00215 ANNABURG MANOR NURSING HOME COST REPORT, MARCH 2002, \$1,582,079

CIN: A-03-96-00012 BCBSM PT-B NON-RENEWAL COSTS, AUGUST 1998, \$1,557,459

CIN: A-09-96-00064 ORT - HOSPICE - CALIFORNIA, MARCH 1997, \$1,350,000

CIN: A-10-91-00011 WPS - KEYSTONE COMPUTER ACQUISITION, OCTOBER 1992, \$1,346,681

CIN: A-05-95-00042 BCBSA ADMINISTRATIVE COSTS - CONTRACTED AUDIT, DECEMBER 1995, \$1,333,598

CIN: A-05-01-00064 REVIEW OF OUTPATIENT REHABILITATION CLAIMS REIMBURSED BY MEDICARE DURING CALENDAR YEAR 1999, FEBRUARY 2002, \$1,235,892

CIN: A-05-00-00004 NEW CENTER COMMUNITY MENTAL HEALTH CENTER, JUNE 2000, \$1,181,000

CIN: A-05-00-00049 PARTNERSHIP PLAN - IL HOSPITAL TRANSFERS, JUNE 2001, \$1,150,113

CIN: A-02-97-01026 EDDY VNA (#337152) HHA ELIGIBILITY REVIEW, SEPTEMBER 1999, \$1,131,593

CIN: A-05-98-00050 FOLLOW-UP MEDICAID CLINICAL LABORATORIES, JULY 1999, \$1,097,036

CIN: A-02-94-01029 HOSPICE ELIGIBILITY RVW IN PR - SAN GERMAN - ORT, JUNE 1995, \$1,070,814

CIN: A-09-98-00052 CALIFORNIA MEDICAL REVIEW INC. (CA. PRO), JANUARY 1999, \$1,067,991

CIN: A-05-01-00037 BC/BS OF MN. ADMIN COSTS - LEON SNEAD & CO., JUNE 2001, \$1,037,090

CIN: A-04-99-01199 REV. PSYCHIATRIC OUTPATIENT SRVCS-CORAL GABLES HOS, APRIL 2001, \$1,031,497

CIN: A-01-98-00500 PAYMENT EDITS FOR PSYCHIATRIC AT MA PART B CARRIER, SEPTEMBER 1998, \$1,000,000

CIN: A-09-94-01010 CLOSEOUT AUDIT - CONT NO. N01-ES-75196 (STRATAGENE), MARCH 1994, \$983,208

CIN: A-04-00-01210 REVIEW TREATMENT - QUALIFIED DISCHRG-BCBSGA, DECEMBER 2000, \$891,000

CIN: A-05-92-00060 CONTRACTOR AUDIT - BCBS - ADMIN, FEBRUARY 1993, \$879,609

CIN: A-02-97-01034 DR. PILA FOUNDATION HOME CARE PRORAM (PONCE), SEPTEMBER 1999, \$857,208

CIN: A-07-98-02533 TRAVELERS FACP, DECEMBER 1998, \$854,214

CIN: A-04-01-05004 REVIEW MEDICARE CLAIMS FOR DEPORTED BENEFICIARIES, MARCH 2002, \$836,711

CIN: A-06-99-00013 MEDICARE PART A ADMIN NM BLUE CROSS BLUE SHIELD, DECEMBER 1999, \$817,487

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CIN: A-02-98-01040 NIAGARA CTY DEPT. OF HLTH-#337001-HHS ELIG REVIEW, DECEMBER 1999, \$807,679

CIN: A-03-99-00008 BLUE CROSS BLUE SHIELD OF DELAWARE - PART A, JANUARY 2000, \$798,939

CIN: A-09-01-00094 PACIFICARE CORPORATE JANUARY 1998 MEDICARE INSTITUTIONAL STATUS, FEBRUARY 2002, \$786,003

CIN: A-07-99-00981 ASSIST REVIEW OF MEDICARE A/R HCFA RO DENVER, JANUARY 2000, \$754,926

CIN: A-06-01-00027 REVIEW PALMETTO'S HH-PPS RAP POLICIES & PROCEDURES, SEPTEMBER 2001, \$743,917

CIN: A-01-01-00509 REVIEW OF OUTPATIENT SUPPLY CHGS @ ST. MARY'S HOSP, SEPTEMBER 2001, \$726,712

CIN: A-09-00-00103 PACIFICARE HMO - MEDICARE DUAL ELIGIBLES, MAY 2001, \$720,858

CIN: A-05-91-00136 COMMUNITY MUTUAL INS CO. ADMIN COSTS, AUGUST 1992, \$720,668

CIN: A-09-97-00078 PHYSICIAN BILLINGS DR. SPENCER, JANUARY 1999, \$683,264

CIN: A-06-01-00090 PREAWARD - APASS MAINTAINER DATA PROCESSING SERVICES-ABCBS, SEPTEMBER 2001, \$678,651

CIN: A-05-00-64226 NA - ILLINOIS DEPT. OF PUBLIC AID, MAY 2000, \$654,017

CIN: A-01-98-00503 PSYCHIATRIC OUTPT SERVICES AT THE FRANKLIN MED CTR, NOVEMBER 1998, \$646,517

CIN: A-01-99-00535 AUDIT OF M/C PART A ADMIN COSTS-ANTHEM BC/BS CT, AUGUST 2000, \$621,256

CIN: A-04-00-00138 MEDICAID ESCHEATED WARRANTS - FLORIDA, JANUARY 2002, \$613,891

CIN: A-06-98-00066 ORT REVIEW OF ULTIMATE HOME HEALTH CARE INC., OCTOBER 1999, \$602,982

CIN: A-04-94-01078 MONITORING ADMIN COST - AUDIT MEDICARE P.B BCBSSC, JULY 1994, \$594,092

CIN: A-04-93-01069 MONITORG ADMIN COST AUDIT MEDICARE PART A BCBSSC, JULY 1994, \$590,844

CIN: A-04-01-01007 GABCBS MEDICARE PART A ADMINISTRATIVE COST AUDIT, NOVEMBER 2001, \$575,471

CIN: A-09-00-00067 COLLEGE HOSPITAL - O/P PSYCH SVCS, APRIL 2001, \$567,888

CIN: A-01-02-70271 STATE OF MAINE , DECEMBER 2001, \$561,697

CIN: A-09-01-00055 REVIEW OF IMD CLAIMS - STATE OF CALIFORNIA, MARCH 2002, \$551,394

CIN: A-05-00-00011 LIBERTYVILLE MANOR SNF - THERAPY SERVICES, SEPTEMBER 2001, \$506,937

CIN: A-05-99-00062 AMERICARE PHYSICAL THERAPY SERVICES, DECEMBER 2000, \$503,619

CIN: A-09-99-56858 HAWAII DEPT. OF HUMAN SERVICES, FEBRUARY 1999, \$502,000

CIN: A-03-92-16229 STATE OF PENNSYLVANIA, MARCH 1992, \$496,876

CIN: A-05-01-67384 MICHIGAN DEPT. OF COMMUNITY HEALTH , FEBRUARY 2001, \$481,693

CIN: A-04-98-01192 REVIEW AMERICA'S BEHAV.HLTH CARE'S PART. HOSPITALIZ, DECEMBER 1999, \$452,928

CIN: A-06-00-00011 FINAL ADMINISTRATIVE COST PROPOSAL - AR BC/BS, NOVEMBER 2000, \$442,177

CIN: A-07-01-00120 REVIEW OF UNFUNDED PENSION COCST AT BCBS OF OK, JULY 2001, \$413,800

CIN: A-05-97-00013 PACIFICARE OF CA - HMO INSTITUTIONAL STATUS PROJECT, APRIL 1998, \$407,784

CIN: A-02-01-67912 STATE OF NEW YORK , MARCH 2001, \$389,622 (Related recommendation of \$19,000,000 outstanding on Table 2)

CIN: A-05-00-00030 CONTRACTED AUDIT - NATIONWIDE INS. - MEDICARE ADMIN., OCTOBER 2000, \$385,081

CIN: A-04-00-01208 OUTPATIENT CLINIC COSTS, CORAL GABLES HOSPITAL, FL, FEBRUARY 2001, \$384,295

CIN: A-09-98-00095 BLUE SHIELD OF CALIFORNIA, OCTOBER 1999, \$378,191

CIN: A-01-01-00516 REVIEW OF MEDICARE OUTLIER PAYMENTS AT BRIGHAM & WOMEN'S HOSPITAL, DECEMBER 2001, \$357,573

CIN: A-01-99-00518 PSYCHIATRIC OUTPATIENT SVCS AT DANBURY HOSPITAL, MAY 2000, \$342,168

CIN: A-10-01-00005 AUDIT OF ADMIN COSTS AT MEDICARE NORTHWEST, SEPTEMBER 2001,  
\$332,274

CIN: A-07-01-02630 REVIEW OF MUTUAL'S SETTLEMENT OF HHA COST REPORTS, JANUARY 2002,  
\$319,949

CIN: A-06-01-00028 AUDIT OF OBSERVATION SERVICE BILLINGS BY PPS HOSPITALS,  
FEBRUARY 2002, \$298,549

CIN: A-05-96-00069 CPA AUDIT OF HOOPER HOLMES HHA G&A -OI CASE OPEN, FEBRUARY 1998,  
\$280,515 (Related recommendation of \$17,555 outstanding on Table 2)

CIN: A-01-00-00511 REVIEW OF O/P PHARMACY SVC-BAYSTATE MED CTR, NOVEMBER 2000,  
\$279,409

CIN: A-06-97-00015 NEW MEXICO PRO CLOSE OUT AUDIT, SEPTEMBER 1999, \$268,844

CIN: A-09-94-30178 STATE OF ARIZONA, JUNE 1994, \$267,021

CIN: A-09-00-00089 COMMUNITY URGENT CARE MEDICAL GROUP, NOVEMBER 2001, \$266,236

CIN: A-03-98-00027 KHPW/INSTITUTIONAL STATUS/MEDICARE, NOVEMBER 1998, \$263,573

CIN: A-03-01-00010 CAREFIRST OF MD - PT-A ADMIN - FYS 1996-1999, FEBRUARY 2002, \$225,302

CIN: A-05-00-60454 ST. CROIX CHIPPEWA OF WISCONSIN, DECEMBER 1999, \$224,452

CIN: A-04-00-01222 CAPITAL HLTH PLAN, COST-BASED MANAGED CARE PLAN, SEPTEMBER 2001,  
\$221,952

CIN: A-01-00-00549 BETH ISRAEL AUDIT OF OUTPATIENT PHARMACY SVC, MARCH 2001, \$221,905

CIN: A-05-99-00067 WPS PART B ADMINISTRATIVE COSTS, NOVEMBER 2000, \$221,644

CIN: A-01-01-00523 REVIEW OF OUTPATIENT PHARMACY SERVICES AT NOBLE HOSPITAL,  
NOVEMBER 2001, \$216,797

CIN: A-02-01-65217 PUERTO RICO DEPT. OF THE FAMILY , DECEMBER 2000, \$213,264

CIN: A-07-01-02095 CONRAD - CPA REPORT ON FACP OF BC/BS OF MONTANA, OCTOBER 2001,  
\$211,086

CIN: A-05-96-00052 ORT ASSIST - ANCILLARY COSTS - NW COM. HOSP., JUNE 1997, \$206,508

CIN: A-06-96-00064 ORT SNF RESEARCH AT METHODIST HOSPITAL, JANUARY 1997, \$200,000

CIN: A-04-01-00002 TITLE IV-E FOSTER CARE PMTS-CHILD CARE CLAIMS-NC-2, NOVEMBER 2001,  
\$186,282

CIN: A-03-01-00555 PDPI INC. - HEAD START, JUNE 2001, \$185,577

CIN: A-07-02-03016 TRANSAMERICA SUPPLEMENTAL PENSION PLAN COSTS, MARCH 2002, \$180,244

CIN: A-06-02-69127 ALL INDIAN PUEBLO COUNCIL INC. , DECEMBER 2001, \$179,889

CIN: A-02-00-01020 BCBS OF WESTERN NY (CARMICHAEL & CO., CPA, APRIL 2001, \$171,631

CIN: A-03-98-00034 FREESTATE HP/INSTITUTIONAL STATUS/MEDICARE, MARCH 1999, \$156,987

CIN: A-09-01-00084 VISTA DEL MAR NEPHROLOGY GROUP, NOVEMBER 2001, \$151,566

CIN: A-05-00-00031 CONTRACTED AUDIT OF UGS - MEDICARE ADMIN. COSTS, NOVEMBER 2000,  
\$138,182

CIN: A-09-99-52846 INTER-TRIBAL COUNCIL OF CALIFORNIA INC., FEBRUARY 1999, \$136,360

CIN: A-03-01-00219 NATIONAL ASSOCIATION OF POTECTION & ADVOCACY -NAPAS,  
SEPTEMBER 2001, \$136,181

CIN: A-02-98-01002 IPRO CLOSEOUT AUDIT - CPA CONTRACT MONITORING, DECEMBER 1998,  
\$135,492

CIN: A-02-00-01019 HORIZON BCBS LEON SNEAD & CO., CPA, SEPTEMBER 2001, \$134,584

CIN: A-05-00-00060 MEDICA FOLLOW-UP, REIMB. RATES FOR INSTI. BENES, JUNE 2001, \$133,795

CIN: A-06-00-00014 REV OF INFUSION THERAPY CLAIMS @ DOCTORS HEALTHCAR, JUNE 2000,  
\$132,238

CIN: A-04-01-68784 STATE OF SOUTH CAROLINA , JUNE 2001, \$129,884

CIN: A-02-01-04000 INTERIM AUDIT OF RUTGER'S CONTRACT NO.SP0103-96-D-, JANUARY 2002,  
\$125,415

CIN: A-02-02-71384 STATE OF NEW YORK , MARCH 2002, \$118,773

CIN: A-09-01-66969 FRESNO INDIAN HEALTH ASSOCIATION INC. , FEBRUARY 2001, \$116,607

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CIN: A-05-97-00023 KAISER FOUNDATION-HMO INSTITUTIONAL STATUS PROJECT, APRIL 1998, \$116,096

CIN: A-02-96-02001 INTERNATIONAL RESCUE COMMITTEE - REFUGEE PROGRAM, JANUARY 1998, \$114,631 (Related recommendation of \$90,528 outstanding on Table 2)

CIN: A-03-99-00003 AETNA-US HEALTHCARE/INSTITUTIONAL STATUS/MEDICARE, JULY 1999, \$113,993

CIN: A-02-96-01001 VNS OF NY HOME CARE - ORT/ HHA TARGET, SEPTEMBER 1997, \$110,841

CIN: A-03-01-00001 EASTERN SHORE AMBULANCE CO., AUGUST 2001, \$110,417

CIN: A-01-00-62266 STATE OF MAINE, MARCH 2000, \$106,500

CIN: A-01-01-00527 REVIEW OF MEDICARE OUTLIER PAYMENTS AT RHODE ISLAND HOSPITAL, FEBRUARY 2002, \$105,686

CIN: A-02-99-58263 PUERTO RICO OFFICE OF THE GOVERNOR OFFICE OF CHILD, JULY 1999, \$101,799

CIN: A-10-00-61811 STATE OF WASHINGTON, JANUARY 2000, \$101,047

CIN: A-09-01-00080 NEPHROLOGY ASSOCIATES MEDICAL GROUP - RIVERSIDE, NOVEMBER 2001, \$100,788

CIN: A-04-01-68839 STATE OF FLORIDA , JUNE 2001, \$98,770

CIN: A-05-00-65775 STATE OF WISCONSIN, SEPTEMBER 2000, \$98,586

CIN: A-07-99-01287 WELLMARK ADMIN COSTS 98, NOVEMBER 1999, \$95,990

CIN: A-09-97-00066 WALTER MCDONALD - INDIRECT COST RATE AUDIT, MARCH 1998, \$95,733

CIN: A-09-01-00096 AUDIT OF VERMONT SLAUSON ECONOMIC DEVELOPMENT CORP. GRANT AWARD NUMBER 90EE0153, DECEMBER 2001, \$95,560

CIN: A-09-98-00065 CSBG DISC. GRANT #90EE004901 - LATINO RESOURCES, JANUARY 1999, \$95,102

CIN: A-01-99-00507 NAT-WIDE REF OPNT PSYCH SVC AT ACUTE CARE HOSPITLS, MARCH 2000, \$94,716 (Related recommendation of \$224,466,692 outstanding on Table 2)

CIN: A-10-97-00003 BCWAAK-ADM COSTS REMOTE NETWORK ACTIVITIES FY93&94, FEBRUARY 1998, \$94,643

CIN: A-07-95-01164 MEDICARE ADMIN COSTS - GENERAL AMERICAN, DECEMBER 1995, \$89,929 (Related recommendation of \$16,632 outstanding on Table 2)

CIN: A-09-02-69757 VERMONT SLAUSON ECONOMIC DEVELOPMENT CORP. & AFFIL, NOVEMBER 2001, \$89,581

CIN: A-06-00-00013 REVIEW OF INFUSION THERAPY CLAIMS @ SPRING CREEK N, JUNE 2000, \$89,288

CIN: A-01-01-00503 REVIEW OF O/P MEDICAL SUPPLIES AT MERCY HOSPITAL, JULY 2001, \$88,904

CIN: A-07-00-00118 REVIEW OF KANSAS RURAL HEALTH CENTER, MAY 2001, \$87,493

CIN: A-08-99-56914 RURAL AMERICA INITIATIVES, JULY 1999, \$87,468

CIN: A-04-01-01006 MBCBS MEDICARE PART A ADMINISTRATIVE COST AUDIT, NOVEMBER 2001, \$87,042

CIN: A-05-01-00071 PAYMENTS TO HUMANA-K.C. FOR INSTITUTIONAL BENEFICIARIES, DECEMBER 2001, \$84,808

CIN: A-10-01-67562 KENAITZE INDIAN TRIBE , MARCH 2001, \$79,533

CIN: A-04-94-02080 FINALIZATION OF BCBSFL DATA MATCH, JUNE 1995, \$79,316

CIN: A-04-01-02003 REVIEW FLORIDA MEDICAID CLAIMS - IMD'S, MARCH 2002, \$78,880

CIN: A-04-96-01137 PARTIC. PART OF HCFA SURV.TEAM - DAYTONA NURSG-ORT, DECEMBER 1996, \$76,130

CIN: A-01-99-00530 NATIONWIDE REV OF O/P PSYCH SVCS @ PSYCH HOSPITALS, DECEMBER 2000, \$75,413 (Related recommendation of \$56,936,287 outstanding on Table 2)

CIN: A-01-00-00503 REVIEW OF MEDICARE OUTLIER PAYMENTS-MASS GENERAL, DECEMBER 2000, \$73,019

CIN: A-08-01-68617 OGLALA SIOUX TRIBE , SEPTEMBER 2001, \$63,011

CIN: A-05-99-00045 KAISER HEALTH PLAN OF OHIO - INSTITUTIONAL STATUS, MAY 2000, \$61,177

CIN: A-05-96-00072 MI DEPT. OF COMMUNITY HEALTH/MEDICAID LAB SERVICES, AUGUST 1997, \$59,956

CIN: A-06-01-68876 STATE OF LOUISIANA , JUNE 2001, \$59,914

CIN: A-01-96-00505 CFO AUDIT OF HCFA'S FINANCIAL STATEMENTS, JULY 1997, \$59,327

CIN: A-02-00-62534 CITY OF NEW YORK NEW YORK, JANUARY 2000, \$58,309

CIN: A-05-96-00051 ORT ASSIST-ANCILLARY COSTS-ST JOSEPH, JUNE 1997, \$58,008

CIN: A-09-97-00059 HEALTH SERVICES ADVISORY GROUP, INC PRO-AZ, MAY 1997, \$57,925

CIN: A-08-99-54138 ROSEBUD SIOUX TRIBE, NOVEMBER 1998, \$56,223

CIN: A-04-00-64899 NA - STATE OF TENNESSEE, JULY 2000, \$55,129

CIN: A-07-97-01206 PENSION - WASHINGTON/ALASKA - UNFUNDED, MARCH 1997, \$54,000

CIN: A-06-00-00053 OIG HCFA NEBULIZER PROJECT - NATIONAL ERROR RATE, OCTOBER 2001, \$52,550 (Related recommendation of \$133,960,552 outstanding on Table 2)

CIN: A-08-00-60687 SOUTH DAKOTA FOUNDATION FOR MEDICAL CARE, NOVEMBER 1999, \$52,536

CIN: A-04-00-01223 REV. MGMT FEES - ONCOLOGY CLINIC-PKWY REG'L MEDICAL, OCTOBER 2001, \$52,000

CIN: A-05-00-00059 TITLE XIX - MEDICAID ESCHEATED WARRANTS, MARCH 2001, \$50,162

CIN: A-02-02-70019 SENECA NATION OF INDIANS, DECEMBER 2001, \$50,083

CIN: A-09-95-00095 HEALTH SERVICES ADVISORY GROUP, INC (HSAG), DECEMBER 1995, \$49,585 (Related recommendation of \$1,389,723 outstanding on Table 2)

CIN: A-03-93-03306 SURVEY RESEARCH ASSOC. CACS NO1-ES-45067, DECEMBER 1993, \$48,779

CIN: A-09-01-68898 STATE OF ARIZONA , JUNE 2001, \$46,237

CIN: A-07-00-00106 PENSION SEGMENTATION AUDIT AT BCBS OF OKLAHOMA, JULY 2001, \$45,508

CIN: A-09-99-52845 INTER-TRIBAL COUNCIL OF CALIFORNIA INC., FEBRUARY 1999, \$43,315

CIN: A-09-99-57306 PICAYUNE RANCHERIA OF THE CHUKCHANSI INDIAN TRIBE, SEPTEMBER 1999, \$43,159

CIN: A-07-01-00121 REV. OF PEN. COSTS FOR MED. REIMB. FOR BCBS OF OK, JULY 2001, \$42,463

CIN: A-03-99-00017 PSU-HERSHEY/PHY CREDIT BALANCES/MEDICARE, DECEMBER 1999, \$41,712

CIN: A-01-01-00507 OUTPATIENT PHARMACY SVCS AT LAWRENCE MEMORIAL HOSP, SEPTEMBER 2001, \$41,210

CIN: A-05-00-00017 INDIANA MEDICAID TRANSPORTATION SERVICES, MARCH 2001, \$39,735

CIN: A-02-95-34275 PUERTO RICO DEPT. OF HEALTH, JUNE 1995, \$37,515

CIN: A-03-97-44742 ASSOCIATION OF TEACHERS OF PREVENTIVE MEDICINE INC, FEBRUARY 1998, \$37,260

CIN: A-07-98-53295 WINNEBAGO TRIBE OF NEBRASKA, SEPTEMBER 1998, \$36,808

CIN: A-10-00-63008 STATE OF IDAHO, MARCH 2000, \$36,800

CIN: A-08-00-65136 STATE OF SOUTH DAKOTA, JUNE 2000, \$36,380

CIN: A-03-00-00010 PS GEISINGER HMO/INSTITUTIONAL STATUS/MEDICARE, JANUARY 2001, \$35,639 (Related recommendation of \$306,269 outstanding on Table 2)

CIN: A-02-00-65502 ABYSSINIAN DEVELOPMENT CORP., AUGUST 2000, \$34,737

CIN: A-04-00-60897 STATE OF FLORIDA, MARCH 2000, \$33,397

CIN: A-09-01-00050 BALBOA NEPHROLOGY MEDICAL GROUP, APRIL 2001, \$32,568

CIN: A-03-99-00004 PSU-GEISINGER/PHY CREDIT BALANCES/MEDICARE, DECEMBER 1999, \$32,165

CIN: A-07-97-01199 BCBS NEW MEXICO UNFUNDED PENSION COST, FEBRUARY 1997, \$31,372

CIN: A-05-02-69155 STATE OF WISCONSIN , DECEMBER 2001, \$30,900

CIN: A-04-01-01005 REVIEW DUPLICATE MEDICARE FEE-FOR-SERVICE PAYMENTS AT CAPITAL HEALTH PLAN, NOVEMBER 2001, \$30,293

CIN: A-03-00-00209 STATE SURVEY AND CERTIFICATION COSTS - VA, AUGUST 2001, \$29,298

CIN: A-03-98-03301 AAUAP - INCURRED COST REVIEW - HHS 105-95-7011, APRIL 1998, \$28,289

CIN: A-03-00-64076 NATIONAL MEDICAL ASSOCIATION, APRIL 2000, \$27,106

CIN: A-10-02-69837 NATIVE VILLAGE OF TYONEK , DECEMBER 2001, \$26,848

CIN: A-05-00-60452 ST. CROIX CHIPPEWA OF WISCONSIN, DECEMBER 1999, \$26,363

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CIN: A-06-00-00020 REV OF INFUSION THERAPY CLAIMS @ VISTA CONTINUING, JUNE 2000, \$25,008  
CIN: A-03-00-00004 GUTHRIE CLINIC/PHYSICIAN CREDIT BALANCES/MEDICARE, DECEMBER 1999,  
\$23,759  
CIN: A-06-02-70732 UNITED STATES-MEXICO BORDER HEALTH ASSOCIATION , JANUARY 2002,  
\$23,483  
CIN: A-06-02-71744 SENECA-CAYUGA TRIBE OF OKLAHOMA , MARCH 2002, \$21,376  
CIN: A-04-00-01206 BCBSNC - MEDICARE PART A ADMIN COST AUDIT - CARMICHAEL,  
SEPTEMBER 2000, \$21,302  
CIN: A-05-02-70624 STATE OF OHIO, JANUARY 2002, \$19,970  
CIN: A-10-02-70455 STATE OF ALASKA , NOVEMBER 2001, \$19,729  
CIN: A-04-01-67441 CATAWBA INDIAN NATION, APRIL 2001, \$19,204  
CIN: A-04-97-01163 VIMI MEDICARE PRO CONTRACT AUDIT, SEPTEMBER 1997, \$18,758  
CIN: A-03-00-00200 GUTHRIE CLINIC/PHYSICIAN CREDIT BALANCES/MEDICAID, DECEMBER 1999,  
\$18,318  
CIN: A-05-93-21928 WRIGHT STATE UNIV., JULY 1993, \$18,308  
CIN: A-09-02-68977 AMERICAN INDIAN FAMILY HEALING CENTER, JANUARY 2002, \$18,081  
CIN: A-01-00-61896 JEWISH FAMILY SERVICE OF STAMFORD INC., DECEMBER 1999, \$18,027  
CIN: A-03-97-00007 NE HEALTH CARE QUALITY FOUNDATION/CCAS/N HAMPSHIRE, MARCH 1997,  
\$17,045  
CIN: A-07-00-00117 REV. OF PENSION COSTS FOR MED. REIMB. BC/BS OF ND, JANUARY 2001, \$16,863  
CIN: A-01-99-55594 STATE OF VERMONT, NOVEMBER 1998, \$16,623  
CIN: A-01-97-44143 BRANDEIS UNIV., JANUARY 1997, \$16,602  
CIN: A-06-01-68297 NATIVE AMERICAN CENTER OF RECOVERY INC., MAY 2001, \$16,314  
CIN: A-01-02-70440 UNIV. OF MASSACHUSETTS , JANUARY 2002, \$16,031  
CIN: A-10-00-59080 NORTON SOUND HEALTH CORP., DECEMBER 1999, \$15,000  
CIN: A-03-97-00008 NE HEALTH CARE QUALITY FOUNDATION/CCAS/VERMONT, MARCH 1997,  
\$14,596  
CIN: A-08-01-67689 FORT BELKNAP INDIAN COMMUNITY, SEPTEMBER 2001, \$14,340  
CIN: A-09-00-00104 PACIFICARE OF CALIFORNIA - INSTITUTIONAL STATUS, MARCH 2001, \$14,278  
CIN: A-06-98-54189 CITY OF HOUSTON TEXAS, JULY 1998, \$14,146  
CIN: A-09-96-00050 CFO - HCFA 1996, NOVEMBER 1997, \$13,924  
CIN: A-10-00-63684 HOH INDIAN TRIBE, APRIL 2000, \$13,602  
CIN: A-07-99-57985 STATE OF KANSAS, FEBRUARY 1999, \$13,550  
CIN: A-03-98-50338 NATIONAL MEDICAL ASSOCIATION, FEBRUARY 1998, \$12,968  
CIN: A-09-00-61853 FRESNO INDIAN HEALTH ASSOCIATION INC., MARCH 2000, \$11,963  
CIN: A-03-01-66421 AMERICAN ASSOCIATION OF COMMUNITY COLLEGES, NOVEMBER 2000,  
\$11,811  
CIN: A-15-01-20002 CONGRESS HEIGHTS TRAINING CENTER, INC. - FINANCIAL AUDIT ON OMH  
GRANT AWARD, SEPTEMBER 2001, \$11,300  
CIN: A-05-01-00070 PAYMENTS TO GHP MCO/ST LOUIS FOR INSTITUTIONAL BENEFICIARIES,  
JANUARY 2002, \$11,089 (Related recommendation of \$98,698 outstanding on Table 2)  
CIN: A-03-01-00513 IRSA - KOSOVO ASSISTANCE GRANT 90-ZK-0002/01, DECEMBER 2001, \$10,913  
CIN: A-07-00-63881 SANTEE SIOUX TRIBE OF NEBRASKA, APRIL 2000, \$10,187  
CIN: A-10-97-00002 GROUP HEALTH INSTITUTIONALIZED, NOVEMBER 1997, \$9,769  
CIN: A-02-01-66887 PUERTO RICO ADMINISTRATION OF CHILDREN & FAMILIES , FEBRUARY 2001,  
\$9,000  
CIN: A-05-01-67360 MICHIGAN FAMILY INDEPENDENCE AGENCY , FEBRUARY 2001, \$8,708  
CIN: A-07-97-01231 PROWEST-DOSHI WASHINGTON, JUNE 1997, \$8,027 (Related recommendation of  
\$163,552 outstanding on Table 2)  
CIN: A-05-00-63666 HO-CHUNK NATION, FEBRUARY 2000, \$7,851  
CIN: A-05-01-68270 LAKE COUNTY COMMUNITY ACTION PROJECT, MAY 2001, \$7,614

CIN: A-03-98-00045 TEMPLE UNIV/PHYSICIAN CREDIT BALANCES/MEDICARE, JULY 1999, \$7,280  
 CIN: A-01-97-49174 BRANDEIS UNIV., AUGUST 1997, \$7,068  
 CIN: A-01-00-61715 STATE OF VERMONT, OCTOBER 1999, \$6,766  
 CIN: A-09-00-58580 TOHONO O ODHAM NATION, NOVEMBER 1999, \$6,456  
 CIN: A-05-02-70333 STATE OF OHIO, JANUARY 2002, \$6,154  
 CIN: A-07-95-01167 PENSION COSTS CLAIMED NEBRASKA BC/BS, JANUARY 1996, \$6,075  
 CIN: A-06-97-48062 SER-JOBS FOR PROGRESS NATIONAL INC., MAY 1997, \$5,924  
 CIN: A-01-00-60299 INDIAN TOWNSHIP TRIBAL GOVERNMENT PASSAMAQUODDY TR,  
 JANUARY 2000, \$4,597  
 CIN: A-04-97-01162 HMSA M'ARE PRO CONTRACT AUDIT, SEPTEMBER 1997, \$3,871  
 CIN: A-09-01-00067 EAST BAY NEPHROLOGY MEDICAL GROUP, AUGUST 2001, \$3,418  
 CIN: A-03-01-03303 JOHNS HOPKINS UNIVERSITY/KPMG/NIDA/N01DA-3-7301, FEBRUARY 2001,  
 \$3,347  
 CIN: A-02-01-01038 EMPIRE BLUE CROSS AND BLUE SHIELD - PARTS A & B (CONRAD &  
 ASSOCIATES), FEBRUARY 2002, \$3,250  
 CIN: A-05-02-69215 ONEIDA TRIBE OF INDIANS OF WISCONSIN, OCTOBER 2001, \$3,109  
 CIN: A-02-01-66889 PUERTO RICO ADMINISTRATION OF CHILDREN & FAMILIES, FEBRUARY 2001,  
 \$3,103  
 CIN: A-03-95-03318 TRANS-MANAGEMENT SYSTEMS 105-92-1527 (CCO), MAY 1996, \$3,016  
 CIN: A-02-01-66888 PUERTO RICO ADMINISTRATION OF CHILDREN & FAMILIES, FEBRUARY 2001,  
 \$2,883  
 CIN: A-06-01-00086 DISCRETIONARY GRANT-HUCKLEBERRY HOUSE BASIC CENTER IN CA,  
 JANUARY 2002, \$2,783  
 CIN: A-07-98-02502 CT. BC/BS PENSION COSTS CLAIMED, MARCH 1998, \$2,725  
 CIN: A-03-98-51505 ALLIEDSIGNAL TECHNICAL SERVICES CORP., APRIL 1998, \$2,722  
 CIN: A-02-97-49366 SENECA NATION OF INDIANS, SEPTEMBER 1997, \$2,655  
 CIN: A-01-97-45487 ABT ASSOCIATES INC., JANUARY 1997, \$2,596  
 CIN: A-08-00-61852 NATIVE AMERICAN SERVICES AGENCY INC., FEBRUARY 2000, \$2,575  
 CIN: A-03-97-43996 ACTUARIAL RESEARCH CORP., OCTOBER 1996, \$2,561  
 CIN: A-03-96-44076 ST. PAULS COLLEGE, AUGUST 1996, \$2,029  
 CIN: A-09-01-00068 ROLLUP REPORT CALIFORNIA INPATIENT HEMODIALYSIS SERVICES,  
 MARCH 2002, \$1,858  
 CIN: A-07-97-01232 PROWEST - DOSHI ALASKA, JUNE 1997, \$1,473 (Related recommendation of \$21,218  
 outstanding on Table 2)  
 CIN: A-07-00-02082 REVIEW OF A COST HMO - IOWA, FEBRUARY 2002, \$1,006

<sup>4</sup> B.

The following audits are in litigation:

CIN: A-05-94-00064 MI BLUE CROSS/BLUE SHIELD, AUDIT OF ADMIN COSTS, JUNE 1996, \$15,609,718  
 CIN: A-07-96-01176 MEDICARE EXCESS PENSION ASSETS - BC MICH, NOVEMBER 1996, \$11,904,263  
 CIN: A-05-96-00058 CLOSE-OUT AUDIT OF MEDICARE CONTRACT - BCBS-MI, DECEMBER 1997,  
 \$5,226,443  
 CIN: A-05-93-00013 MI-BLUE CROSS/BLUE SHIELD - CONTRACT MEDICARE AUDIT, APRIL 1993,  
 \$3,010,916  
 CIN: A-07-92-00579 BC/BS OF MICHIGAN INC - UNFUNDED PENSION COSTS, OCTOBER 1992,  
 \$2,535,698  
 CIN: A-05-95-00059 AUDIT OF ADMINISTRATIVE COSTS - BCBS MICHIGAN, JANUARY 1997,  
 \$1,787,345  
 CIN: A-05-93-00057 MI-BLUE CROSS & BLUE SHIELD OF MI - CONTRACT AUDIT, JULY 1993,  
 \$1,409,954  
 CIN: A-05-94-00047 NATIONWIDE INS., MEDICARE PART B ADMIN. COSTS, SEPTEMBER 1995,  
 \$1,049,309

*Appendix D*

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**Notes to Table 2**

<sup>1</sup>The opening balance was adjusted upward by \$199 million.

<sup>2</sup>Management decision has not been made within 6 months on 25 reports.

Discussions with management are ongoing and it is expected that the following audits will be resolved by the next semiannual reporting period:

CIN: A-03-00-00203 PA/INTERGOVERNMENTAL TRANSFERS/MEDICAID, FEBRUARY 2001, \$3,700,000,000  
CIN: A-05-00-00056 MEDICAID INTERGOVERNMENTAL TRANSFERS - IDPA, MARCH 2001, \$1,870,000,000  
CIN: A-06-00-00023 MEDICAID PHARMACY/PHYSICIAN ACTUAL ACQUISITION COS, AUGUST 2001, \$1,080,000,000  
CIN: A-10-00-00011 MEDICAID INTERGOVERNMENTAL TRANSFERS - WA STATE, MARCH 2001, \$475,000,000  
CIN: A-06-01-00069 EVALUATION OF LEGISLATION TO INCREASE MEDICAID HOSP - SPEC DSH PYMT LIMITS, DECEMBER 2001, \$380,000,000  
CIN: A-04-00-02165 REVIEW OF AL MEDICAID INTERGOVERNMENTAL TRANSFERS, MARCH 2001, \$147,500,000  
CIN: A-04-00-02169 REV. AL MEDICAID INTERGOVERNMENTAL TRANSFERS-HOSPITAL ENHANCE, MAY 2001, \$63,000,000  
CIN: A-07-98-02534 EMPIRE BC/BS PENSION PLAN TERMINATION, MARCH 2000, \$38,626,351  
CIN: A-04-97-00109 EMERGENCY ASSISTANCE CLAIMS - NC, JULY 1998, \$13,000,000  
CIN: A-01-99-00506 FOLLW-UP REVIEW OF SEPRTLY BILLABLE ESRD LAB TESTS, JANUARY 2001, \$12,200,000  
CIN: A-06-99-00060 REVIEW OF AN HMO UNDERPAYMENT CLAIM OF 21 MILLION, JUNE 2001, \$12,191,579  
CIN: A-01-00-00502 REV OF EXORBITANT MEDICARE PMTS FOR O/P SVCS, MAY 2001, \$12,100,000  
CIN: A-07-96-01177 MEDICARE POST RETIREMENT CLAIM BC MICH, NOVEMBER 1996, \$8,978,998  
CIN: A-06-99-00045 MEDICARE LEFT AGAINST MEDICAL ADVICE DISCHARGES, MARCH 2002, \$6,800,000  
CIN: A-01-97-02506 REVIEW OF THE AVAIL OF MEDICAL COVERAGE/CSE SUPORT, JUNE 1998, \$5,704,585  
CIN: A-06-00-00073 REV OF MGR CARE ADDTL BENEFITS FOR CY 00 OF NYLCAR, MARCH 2002, \$4,000,000  
CIN: A-04-98-01188 REVIEW ADMIN. COSTS @ MEDICARE MANAGED RISK PLAN, AUGUST 1999, \$2,559,357  
CIN: A-05-00-00083 REVIEW OF MEDICAID DME CLAIMS - MICHIGAN, OCTOBER 2001, \$2,500,000  
CIN: A-05-01-00031 WI MEDICAID - DME, OCTOBER 2001, \$1,250,000  
CIN: A-01-01-01501 REVIEW OF YALE UNIVERSITY SCHOOL OF MEDICINE'S GCRC, DECEMBER 2001, \$600,000  
CIN: A-05-00-00057 REVIEW OF MEDICAID MUTUALLY EXCLUSIVE CODES-OH, NOVEMBER 2001, \$450,000  
CIN: A-05-01-00074 REVIEW OF BID PROPOSAL RFP HCFA-01-0003, JUNE 2001, \$282,049  
CIN: A-07-97-01230 OFMQ - DOSHI OKLAHOMA, JUNE 1997, \$203,510  
CIN: A-01-97-00526 PSYCHIATRIC OUTPATIENT SERVICES, MARCH 1998, \$7,245  
CIN: A-01-98-00506 PSYCHIATRIC OUTPATIENT AT NEWTON-WELLESLEY HOSPITAL, MARCH 1998, \$1,120

***Appendix E***  
***Reporting Requirements of the Inspector General Act of 1978, as Amended***

The specific reporting requirements of the Inspector General Act of 1978, as amended, are listed below with reference to the page in the semiannual report on which each is addressed. Where there are no data to report under a particular requirement, the word “none” appears in the column. A complete listing of audit and inspection reports is being furnished to the Congress under separate cover. Copies are available upon request.

<b><i>Section of the Act</i></b>	<b><i>Requirement</i></b>	<b><i>Page</i></b>
Section 4(a)(2)	Review of legislation and regulations	47
Section 5		
(a)(1)	Significant problems, abuses and deficiencies	Throughout
(a)(2)	Recommendations with respect to significant problems, abuses and deficiencies	Throughout
(a)(3)	Prior significant recommendations on which corrective action has not been completed	Appendices B & C
(a)(4)	Matters referred to prosecutive authorities	48
(a)(5)	Summary of instances where information was refused	None
(a)(6)	List of audit reports	Under separate cover
(a)(7)	Summary of significant reports	Throughout
(a)(8)	Statistical Table 1—Reports With Questioned Costs	45
(a)(9)	Statistical Table 2—Funds Recommended to Be Put to Better Use	46
(a)(10)	Summary of previous audit reports without management decisions	Appendix D
(a)(11)	Description and explanation of revised management decisions	Appendix D
(a)(12)	Management decisions with which the Inspector General is in disagreement	None



## *Appendix F*

### *Summary of Sanction Authorities*

The Inspector General Act of 1978 (Public Law 95-452), as amended, sets forth specific requirements for semiannual reports to be made to the Secretary for transmittal to the Congress. A selection of other authorities appears below:

#### ***Program Exclusions***

Section 1128 of the Social Security Act (42 U.S.C. § 1320a-7) provides several grounds for excluding individuals and entities from participation in Medicare, Medicaid and other federal health care programs. Exclusions are required for individuals and entities convicted of the following types of criminal offenses: 1) Medicare or Medicaid fraud; 2) patient abuse or neglect; 3) felonies for other health care fraud; and 4) felonies for illegal manufacture, distribution, prescription or dispensing of controlled substances. The OIG has the discretion to exclude individuals and entities on several other grounds, including: misdemeanors for other health care fraud (other than Medicare or Medicaid) or for illegal manufacture, distribution, prescription or dispensing of controlled substances; suspension or revocation of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity; provision of unnecessary or substandard services; submission of false or fraudulent claims to a federal health care program; and engaging in unlawful kickback arrangements.

Providers who are subject to exclusion are granted due process rights, including a hearing before an HHS administrative law judge and appeals to the HHS Departmental Appeals Board and the federal district and appellate courts, regarding whether the basis for the exclusion exists and the length of the exclusion is reasonable.

#### ***Patient Dumping***

Section 1867 of the Social Security Act (42 U.S.C. § 1395dd) provides that when an individual presents to the emergency room of a Medicare-participating hospital, the hospital must provide an appropriate medical screening examination to determine whether that individual has an emergency medical condition. If an individual has such a condition, the hospital must provide either: 1) treatment to stabilize the condition; or 2) an appropriate transfer to another medical facility.

If a transfer is ordered, the transferring hospital must provide stabilizing treatment to minimize the risks of transfer and must ensure that the receiving hospital agrees to the transfer and has available space and qualified personnel to treat the individual. In addition, the transferring hospital must effect the transfer through qualified personnel and transportation equipment. Further, a participating hospital with specialized capabilities or facilities may not refuse to accept an appropriate transfer of an individual who needs services if the hospital has the capacity to treat the individual.

The OIG is authorized to collect civil monetary penalties of up to \$25,000 against small hospitals (less than 100 beds) and up to \$50,000 against larger hospitals (100 beds or more) for each instance in which the hospital negligently violated any of the section 1867 requirements. In addition, OIG may collect a penalty of up to \$50,000 from a responsible physician for each negligent violation of any of the section 1867 requirements and, in some circumstances, may exclude a responsible physician.

### ***Civil Monetary Penalties Law***

Under the Civil Monetary Penalties Law (CMPL), section 1128A of the Social Security Act, 42 U.S.C. § 1320a-7a, a person is subject to penalties, assessments, and exclusion from participation in federal health care programs for engaging in certain activities. For example, a person who submits to a federal health care program a claim for items and services that the person knows or should know is false or fraudulent is subject to a penalty of up to \$10,000 for each item or service falsely or fraudulently claimed, an assessment of up to three times the amount falsely or fraudulently claimed, and exclusion.

For the purposes of the CMPL, “should know” is defined to mean that the person acted in reckless disregard or deliberate ignorance of the truth or falsity of the claim. The CMPL also authorizes actions for a variety of other violations, including submission of claims for items or services furnished by an excluded person, requests for payment in violation of an assignment agreement, and payment or receipt of remuneration in violation of the anti-kickback statute (42 U.S.C. § 1320a-7b(b)). The authority to bring CMPL cases has been delegated to the Inspector General.

### ***Anti-Kickback Statute***

The anti-kickback statute authorizes penalties against anyone who knowingly and willfully solicits, receives, offers or pays remuneration, in cash or in kind, to induce or in return for 1) referring an individual to a person or entity for the furnishing, or arranging for the furnishing, of any item or service payable under the federal health care programs; or 2) purchasing, leasing or ordering, or arranging for or recommending the purchasing, leasing or ordering of any good, facility, service or item payable under the federal health care programs. (Section 1128B(b) of the Social Security Act, 42 U.S.C. § 1320a-7b) Individuals and entities that engage in unlawful referral or kickback schemes may be subject to criminal penalties under the general criminal anti-kickback statute, civil monetary penalties under OIG’s CMPL authority (Section 1128A(a)(7) of the Social Security Act, 42 U.S.C. § 1320a-7a) and/or program exclusion under OIG’s permissive exclusion authority (Section 1128(b)(7) of the Social Security Act, 42 U.S.C. § 1320a-7(b)(7)).

### ***False Claims Act***

Under the federal civil False Claims Act (FCA), 31 U.S.C. §§ 3729-3733, a person or entity is liable for up to treble damages and up to \$11,000 for each false claim it knowingly submits or causes to be submitted to a federal program. Similarly, a person or entity is liable under the FCA if it knowingly makes or uses, or causes to be made or used, a false record or statement to have a false claim paid. The FCA defines “knowing” to include not only the traditional definition, but also instances when the person acted in deliberate ignorance of the truth or falsity of the information or in reckless disregard of the truth or falsity of the information. Under the FCA, no specific intent to defraud is required. Further, the FCA contains a *qui tam* or whistleblower provision that allows private individuals to file suit on behalf of the United States and entitles that whistleblower to a percentage of any fraud recoveries.

**Appendix G**  
**Status of Public Proposals for New and Modified Safe Harbors  
to the Anti-Kickback Statute Pursuant to Section 205 of the  
Health Insurance Portability and Accountability Act of 1996**

Pursuant to section 205 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, the Inspector General is required annually to solicit proposals (via *Federal Register* notice) for modifying existing safe harbors to the anti-kickback statute and for developing new safe harbors and special fraud alerts.

In crafting safe harbors for a criminal statute, it is incumbent upon OIG to engage in a complete and careful revisit of the subject area, so as to uncover all potential opportunities for fraud and abuse by unscrupulous providers. Having done so, OIG must then determine, in consultation with the Department of Justice, whether it can develop regulatory limitations and controls that will permit beneficial or innocuous arrangements, while also protecting the federal health care programs and their beneficiaries from abusive practices.

In response to the 2001 annual solicitation, OIG received 22 timely responses containing the following proposals related to safe harbors:

<b><i>Proposal</i></b>	<b><i>OIG Response</i></b>
New safe harbor for certain fee-for-service arrangements between federally-qualified health centers (FQHCs) and other providers, practitioners, and suppliers.	The OIG is developing a proposed rule on this proposal.
Modification of existing rental and services safe harbors to include “per use” or “per click” fees.	The OIG is not adopting this suggestion because arrangements that use “per use” or similar “per click” fees are often abusive and should be reviewed on a case-by-case basis, such as under the advisory opinion procedures.
Modification of the existing safe harbors to conform them to the final regulations under the physician self-referral statute published by CMS on January 4, 2001.	The OIG is considering this suggestion with respect to the group practice safe harbor. With respect to other safe harbors, the statutes generally serve somewhat different purposes and conforming the safe harbors to the self-referral exceptions may not be appropriate. The OIG may consider making some conforming changes, if appropriate, once the self-referral regulations are completed in their entirety.
New safe harbors analogous to the new self-referral exceptions created by the CMS regulations (e.g., compliance training, incidental benefits, non-monetary compensation).	The OIG is considering this suggestion.
New safe harbor for isolated transactions matching the exception in the physician self-referral statute.	The OIG will consider this suggestion after CMS issues final self-referral regulations on the subject.

Appendix G

<p>New safe harbor for any payment from a faculty practice plan affiliated with an academic medical center to a faculty member for clinical practice services.</p>	<p>The OIG is not adopting this suggestion because, among other concerns, the specific proposal contains no fair market value limitation.</p>
<p>New safe harbor for academic medical center arrangements that would protect both compensation and ownership relationships within an academic medical center.</p>	<p>The OIG is not adopting this suggestion, as the specific proposal is vague and lacks adequate safeguards.</p>
<p>Modification of the existing shared risk exception to cover second tier contractors of FQHCs.</p>	<p>The OIG is considering this suggestion.</p>
<p>Modification of the safe harbor for ambulatory surgical centers (ASCs) jointly owned by hospitals and physicians to add conditions under which a hospital would not be in a position to make or influence referrals.</p>	<p>The OIG is considering this suggestion.</p>
<p>Modification of the ASC safe harbor to add an alternative to the “1/3-1/3 tests” for referrals consisting exclusively of personally performed services.</p>	<p>The OIG is not adopting the proposed alternative test because it would protect investments by physicians for whom the ASC is not an extension of their offices, but who would nevertheless share in the technical components of services. Such arrangements are subject to abuse and should be evaluated on a case-by-case basis, such as under the advisory opinion procedures.</p>
<p>Modification of the ASC safe harbor to clarify whether an ASC can require: 1) investors to comply with safe harbor conditions and 2) a retiring physician to divest his or her interest.</p>	<p>The OIG is considering the first of these suggestions. The second suggestion is inconsistent with the anti-kickback statute and poses a risk of abuse. Specific cases should be evaluated on a case-by-case basis, such as under the advisory opinion procedures.</p>
<p>Modification of the ASC safe harbor to protect an otherwise qualifying physician investor even if certain other investors (e.g., employees or anesthesiologists) are not protected.</p>	<p>The OIG is not adopting this suggestion, as it would create an unclear rule that would be impractical from both a compliance and an enforcement perspective.</p>
<p>Modification of the ASC safe harbor to permit investments by multi-specialty group practices that include physicians who do not perform ASC services.</p>	<p>The OIG is not adopting this suggestion. In the arrangements described, referral-source physicians receive direct or indirect compensation for their ASC referrals. Such arrangements are subject to abuse and should be addressed on a case-by-case basis, such as under the advisory opinion procedures.</p>
<p>Modification of the ASC safe harbor to allow separately billed ancillary services or, alternatively, to incorporate the new physician self-referral exceptions for implants, contact lenses, and integral radiology.</p>	<p>The OIG is not adopting this suggestion, as there is a substantial risk of abuse when physicians own interests in ancillary services. The ASC ventures involving ancillary services should be addressed on a case-by-case basis, such as under the advisory opinion procedures.</p>

Modification of the ASC safe harbor to clarify 1) the use of “pass-through” entities to hold ownership interests and 2) the treatment of physician investors who invest at different times.	The OIG is considering these suggestions.
New safe harbor for fees charged by internet providers of directory, connectivity, and referral services.	The OIG is not adopting this suggestion. Given the range and evolution of potential internet arrangements, it would be impracticable to craft appropriate safeguards. Moreover, some arrangements pose a risk of abuse. Internet arrangements are best addressed on a case-by-case basis (such as under the advisory opinion procedures) under traditional anti-kickback principles.
New safe harbor for “home health case finding” activities conducted by certain entities through physician practice preferred provider networks.	The OIG is not adopting this suggestion, because “home health case finding” activities pose a risk of abuse under the anti-kickback statute.
New safe harbor for rural health networks operating pursuant to the Medicare Rural Hospital Flexibility Program.	The OIG is considering this suggestion.
New safe harbor for arrangements that comply with section 513 of the IRS Code pertaining to the provision of certain supporting goods and services by tax-exempt hospitals to other tax-exempt hospitals.	The OIG is considering this suggestion.
New safe harbor for loans made by financing affiliates formed by manufacturers and distributors, if the loans are at fair market value with commercially reasonable rates and terms.	The OIG is not adopting this suggestion, because the lending arrangements described in the proposal could be subject to abuse and should be addressed on a case-by-case basis, such as under the advisory opinion procedures. It would be difficult in a safe harbor to specify the parameters of “commercially reasonable rates and terms” in a manner that would result in an appropriate safe harbor.
New safe harbors for a variety of pharmaceutical company arrangements, including: 1) payments by manufacturers to PBMs analogous to the GPO safe harbor; 2) the purchase of data and related services from PBMs, MCOs, and similar organizations; 3) commission sales arrangements; 4) payments by manufacturers to providers for phase 1, 2, 3, and 4 research studies; 5) disease management and patient compliance programs; 6) pharmaceutical sample programs; and 7) pharmaceutical coupon programs.	The OIG will not adopt these suggestions. The practices addressed are potentially abusive under the anti-kickback statute and should be addressed on a case-by-case basis, such as under the advisory opinion procedures.
Modification of the shared risk safe harbor to clarify its application to manufacturers, PBMs, and MCOs that may not buy or receive products directly from the manufacturers.	The OIG is not adopting this suggestion. This proposal was considered and declined by the negotiated rule-making committee that established the shared risk safe harbor.
Modification of the discount safe harbor to clarify its application to discounts applied to a manufacturer’s full product line.	This suggestion requires further study.

Appendix G

Modification of the discount safe harbor's reporting requirements.	This suggestion requires further study.
New safe harbor based on "rule of reason."	The OIG is not adopting this suggestion as it is vague, overly-broad, and contrary to the "one purpose" test.

In addition to the proposals in the preceding table (some of which duplicate proposals from past years), OIG has had under consideration the following suggestions from prior years:

<i>Proposal</i>	<i>OIG Response</i>
New safe harbor for <i>de minimis</i> gifts to beneficiaries who refer new customers.	The OIG is considering this suggestion.
New safe harbor for investments made by potential recipients of referrals in an investment entity that is a source of referrals.	The OIG is not adopting this suggestion as it would be impracticable to develop appropriate safe harbor conditions. These investment arrangements are best reviewed on a case-by-case basis, such as under the advisory opinion procedures.
Modification of the existing safe harbors that rely on Health Professional Shortage Area (HPSA) designations with alternate measures of under-served areas.	The OIG is not adopting this suggestion because the OIG has been unable to identify a clear, measurable, and objective alternative designation.
Modification of the GPO safe harbor to restrict fees.	The OIG is not adopting this suggestion as the OIG does not have authority to narrow the scope of the statutory exception absent a legislative amendment.
Modification of the safe harbors generally to exclude from protection business arrangements involving parties previously sanctioned by Medicare or Medicaid.	The OIG is not adopting this suggestion as it is impracticable in the context of the overall safe harbor regulations. In many cases, such arrangements are effectively barred under the exclusion authorities.
New safe harbor for referrals of eyeglasses and contact lenses sold by optical stores and for intraocular lenses furnished during surgical procedures.	The OIG is not adopting this suggestion because the arrangements described pose a risk of abuse under the anti-kickback statute and should be evaluated on a case-by-case basis, such as under the advisory opinion procedures.
New safe harbor for arrangements with independent sales representatives and sales service companies that use an employed sales force to sell another company's products.	The OIG is not adopting this suggestion because the arrangements described pose a risk of abuse under the anti-kickback statute and should be evaluated on a case-by-case basis, such as under the advisory opinion procedures.
New safe harbor for continuing education programs sponsored by manufacturers, commercial laboratories, and other providers for facilities and practitioners with which they have referral relationships.	The OIG is not adopting this suggestion because the arrangements described pose a risk of abuse under the anti-kickback statute and should be evaluated on a case-by-case basis, such as under the advisory opinion procedures.

New safe harbor for payments between related entities, including parent companies and wholly owned subsidiaries.	The OIG is not adopting this suggestion because the arrangements described pose a risk of abuse under the anti-kickback statute and should be evaluated on a case-by-case basis, such as under the advisory opinion procedures.
New safe harbor for marketing of Medicare managed care plans by independent insurance underwriters.	The OIG is not adopting this suggestion as it is unnecessary given existing CMS rules governing marketing of managed care plans.
New safe harbor for flat rate fees charged to Medicare patients for outpatient surgeries.	The OIG is not adopting this suggestion as it is unnecessary given implementation of the outpatient prospective payment system.



## *Appendix H*

### *Performance Measure*

Performance measures are used to evaluate the achievement of a program goal, such as the efficiency of an immunization program measured by the number of inoculations provided per dollar of cost. The OIG has identified some items throughout this report as **performance measures** by placing the symbols ❖❖ following the items. In OIG's opinion, the audits, inspections and investigations identified with the performance measure symbol offer management information about whether some aspect or all of the programs or activities reviewed are achieving their missions and goals. These proposals are provided to management for their consideration as they develop their performance measures.

The following reports warrant the performance measure symbols:

Clinical Trial Web Sites

FY 2001 Financial Statement Audits

Recruiting and Retaining Foster Parents

Insurance Intercept Program

FY 2001 Financial Statement Audit: Administration on Aging

Results Act

FY 2001 Financial Statement Audit: Program Support Center



## *Office of Inspector General Components*

***Office of Audit Services (OAS)***—provides all auditing services for HHS, either through its own resources or by overseeing audit work of others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse and mismanagement and to promote economy and efficiency throughout the Department.

***Office of Counsel to the Inspector General (OCIG)***—provides legal services to OIG, rendering advice and opinions on HHS programs and operations, imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, and renders advisory opinions on sanctions to the health care community.

***Office of Evaluation & Inspections (OEI)***—conducts short-term management and program evaluations that focus on issues of concern to the Department, the Congress and the public. The OEI generally focuses on programs with significant expenditures of funds and services to program beneficiaries or in which important management issues have surfaced. The findings and recommendations contained in the reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability and effectiveness of departmental programs.

***Office of Investigations (OI)***—conducts criminal, civil and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. Investigative efforts lead to criminal convictions, administrative sanctions or civil monetary penalties. The OI serves as liaison to the Department of Justice on all matters relating to investigations of HHS programs and personnel. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

***Office of Management and Policy (OMP)***—provides mission support services to the IG and other components. The OMP formulates and executes the budget, develops policy, disseminates OIG information to the news media and public, liaises with the Department, Congress, and external organizations and manages information technology resources. The OMP also conducts and coordinates reviews of existing and proposed legislation and regulations to assess implications and economic consequences for HHS programs and operations.

